THERAPEUTIC ATTITUDES

AND THE ACQUISITION OF COMPETENCE DURING TRAINING IN COGNITIVE BEHAVIOUR THERAPY

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ABSTRACT

Psychotherapy has differentiated into models of practice based on diverse principles. Current policies in the UK favour expansion of empirically supported treatments, especially cognitive behaviour therapy (CBT). This is likely to result in therapists seeking training in CBT after previously adhering to other models.

This study aimed to test whether adherence to another model would inhibit acquisition of CBT skills. It also sought to find out how such inhibition might be overcome. Previous studies researched the effect of model adherence on training but without measuring the effect on skill learning (Persons et al, 1996; Freiheit & Overholser, 1997).

The author devised the Cognitive Behaviour Therapy Training Questionnaire and used it to track trainee attitudes before and after training and at one year follow-up. He also interviewed trainees about their experiences of training. A group of assessors rated trainees' competencies in CBT skills using the Cognitive Therapy Scale – Revised.

The results show that trainees with previous adherence to psychodynamic and person-centred therapy (PCT) showed less than average adherence to CBT principles. CBT skill performances by psychodynamic trainees however were not inhibited by these attitudes. The performances of PCT trainees showed some significant difficulties in CBT skill acquisition, especially during early stages of training. Apart from for a few PCT trainees whose competence development was delayed, however, these difficulties were overcome. PCT trainees reported more 'task interfering cognitions' about skill acquisition, especially those connected with structuring therapy. Most of them reported that they were able to overcome these difficulties by developing more relaxed attitudes towards assessment and rethinking certain specific attitudes.

In conclusion, certain specific attitudes connected with other models may inhibit trainees in the acquisition of CBT skills. Trainees can, however, generally overcome these difficulties by rethinking specific attitudes and by avoiding overly rigid and fearful attitudes toward assessment.

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AUTHOR'S DECLARATION

I declare that the work in this dissertation was carried out in accordance with the Regulations of the University of Bristol. The work is original except where indicated by special reference in the text, and no part of the dissertation has been submitted for any other academic award. Any views expressed in the dissertation are those of the author.

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Chapter 1: Introduction

An increasing number of graduate students and professionals from a variety of other backgrounds may desire training in cognitive-behavioural approaches. A central issue not yet addressed by the current cognitive behavioural training literature is how to teach cognitive behavioural techniques to individuals from other therapeutic orientations effectively (Freiheit & Overholser, 1997, p.79).

Like patients, trainees arrive in the classroom with value-laden models of psychopathology and psychotherapy that are not fully conscious or articulated and that they are not eager or able to summarily relinquish. The teacher's job is to help trainees become aware of their pre-existing penchants and predispositions, examine them, and acquire new information that allows them to make whatever adjustments they might wish to make to their own working models. ... Thus, we argue that an important strategy for overcoming obstacles to teaching and learning is to make the obstacles explicit and to promote flexible, thoughtful examination of them... Our experience is that willingness to try a new idea or new intervention is a key step in learning a new model (Persons et al, 1996 p. 212).

The above quotations describe the practice of training therapists in cognitive-behavioural therapy (CBT) within arenas where many of the trainees held prior preferences for other therapy models, usually the psychodynamic and/or humanistic models. Persons et al (1996) found that a previous training in psychodynamic therapy led trainees to have considerable reservations about the CBT model. These reservations are described in Chapter 3. This present study, like those above, is also concerned with the training of therapists in CBT and with the effect that any such reservations held on entering training might have on the process and outcomes of that training, especially with acquisition of competent practice skills.

The trainees in this study came from a variety of practice and training backgrounds. Some showed reservations about CBT similar to those described by Persons et al (1996). Person-centred and humanistic models of practice are, however, more common in the backgrounds of counsellor participants in this study partly because of the strong influence of the person-centred model in the development of counselling (McLeod, 2003) than in the studies of Persons et al (1996) and Freiheit & Overholser (1997). This study is therefore particularly interested in the way that any principles and methods of practice that have been developed within previous training in humanistic therapy might influence learning CBT. The study, however, also has a wider focus of concern in that holding

principles of a previously held model is only one possible trainee characteristic that may influence the learning of CBT.

The study was set in the context of the training process for CBT. It aimed to distinguish the therapeutic attitudes of trainees, the nature of the training process and how these two factors interact. In order to understand how the research questions were formulated, this Introduction will describe how CBT developed within the context of a field with multiple bases of knowledge. It will then briefly introduce the aims and proposed methods of the study on CBT training.

1.1: Background to the Study: The Development of Psychological Therapy:

Although the origins of psychological therapy have been traced as far back as Ancient Greece (Xenakis, 1969), it appears in its modern form with the work of Freud and his colleagues at the end of the 19th Century. Freud's work eventually developed into a 'school' of psychotherapy, which was termed psychoanalytic and, later and more broadly, psychodynamic. During the 20th Century, psychotherapy expanded rapidly, especially after World War II, and also influenced many of the other helping professions, such as counselling and social work. The psychodynamic perspective is based on certain specific concepts and values regarding the nature of the person, the development of psychopathology and the processes of psychological change.

Many psychodynamic concepts and values proved to be controversial and the Freudian perspective soon found many critics. Some of these critics went on to establish schools based on quite opposite principles. Behaviourism, for example, developed in reaction against the so-called 'mentalism' involved in the concept of the 'unconscious' and wanted to focus more on observable and concrete behaviour. Behaviourism has had several cycles of development. The early breakthrough came in the 1920s with the work of Watson. A big expansion in US psychology in the 1920s followed on from the work of Watson, and another surge in behavioural psychology came in the 1950s onwards from the work of Skinner. More recently, behaviourism has tended to join forces with the

cognitive perspective in both general psychology and in the therapeutic field forming a broad school of therapy now termed 'cognitive-behavioural' (Rachman, 1997b).
Another reaction against psychoanalytic thinking came in the shape of the Humanistic school, starting with the work of Carl Rogers from the 1940s onward. Here the reaction against Freudian concepts was focussed on the alleged 'pessimism' of its theory and the 'directiveness' of its practice (Rogers & Russell, 2002). Humanistic therapists have been concerned to evolve a model of practice that was based on the idea that human growth processes are natural and 'self-actualising' (Rogers, 1951; 1967). Existential therapy, however, is usually bracketed within the humanistic school, yet dissents from this view of human nature (van Deurzen-Smith, 2002).

The expansion of schools of therapy has appeared to be exponential. In a review of the field, Norcross & Arnkoff (1992) reported that they had been able to identify over 400 models of practice. They could detect no sign of decreasing growth in the number of models and suggested that only 'narcissistic fatigue' would stop the expansion. Many of these schools are very small and operate as splinters or sub-groups of others.

The three main schools introduced above: Psychodynamic, Humanistic and Cognitive-Behavioural - remain the three of the four most dominant paradigms in the field – the fourth being Eclectic or Integrative. A survey of counsellors in 1993 revealed that 75% of counsellors described themselves as practising within one of these 3 broad schools, whilst most of the rest described themselves as 'eclectic or integrative' in their practice (BACP, 2002). The trend of practitioners divided between theoretical and practical 'schools' has been evident in other helping professions, such as clinical psychology and social work. In effect, this means that psychological therapies are practised in fields that are theoretically fragmented and where no one approach holds a dominant position. It also means that the professions involved do not always share assumptions amongst themselves and may have difficulty in finding a common language to talk about issues within the professions involved in psychological therapy and in representing the profession to outside bodies. In discussing relations between the schools, however, it is

also wise to be aware of the possibility that a 'uniformity myth' (Kiesler, 1966) will exaggerate the uniformity of attitudes within each school.

This thesis is concerned primarily, however, with training in the skills of CBT. It is important to locate the context of such training in a field where knowledge is fragmented, as described above. This fragmentation means that trainees may approach CBT training with a variety of different attitudes that may help or hinder learning this model. This study is centrally concerned with the interaction between the beliefs and attitudes about how therapy is practiced that trainees hold as they come into training and the way training itself modifies – or fails to modify - attitudes. This aim has a certain congruence with many of the activities of cognitive therapy during which the therapist helps clients to develop ways of modifying their thinking in order to evolve a form of functioning that is closer to their life goals (Beck, 1995).

The study is also interested in how trainees achieve behavioural competence in practising the therapy and how this is influenced by attitudes of trainees at the start of training. This focus on behavioural competence has congruence with the aims of behavioural therapy. Persons (1989, 1995; Persons et al, 1996) have argued that CBT reaches maximal effectiveness when carefully individual assessments of clients result in formulation of how their individual cognitive and behavioural patterns have evolved and are maintained.

CBT is a form of psychological therapy based on the assumption that certain psychological problems have their origins in, and are maintained, by patterns of maladaptive schemas[1], cognitions, emotion and behaviour. The 'cognitive specificity hypothesis' maintains that specific psychological problems have specific types of thinking patterns (Salkovskis, 1996). The therapist works to build a formulation specifying the pattern elements and the relationship between them for each individual client. Therapist and client then collaboratively plan a series of interventions to produce ameliorative change in maladaptive patterns. The modern form of CBT first arose in the 1960s, as the more cognitive approaches of Ellis and Beck developed and then combined

[1] CBT practitioners have preferred the use of the plural term 'schemas' to the more correct 'schemata'.

with already evolving behavioural approaches. This history is more fully described in the following section. This study is particularly concerned with the fusion of the cognitive tradition of Beck with the principles of behaviour therapy. Stressing a "formulation model" is an influential mode of training within CBT education in Britain (BABCP, 1999) and is the training model used on the course programme within which this study is located (UWCN, 2004). The term 'cognitive behavioural therapy', CBT, will be used as the wider parent school within which various models of practice can be securely defined. Both Hawton et al (1989) and Rachman (1997b) describe CBT as the integration of behaviour therapy and cognitive therapy. This integration is possible because key principles are so similar. The term 'cognitive therapy' refers to the particular contributions of Aaron Beck to the wider parental CBT approach.[2]

1.2: The evolution of CBT

The evolution of CBT took place in three stages: the development of behavioural therapy, the development of cognitive therapy and the fusion of these therapies into an overall model: CBT (Rachman, 1997b). Each stage of development will be described along with brief consideration of whether there is an imminent 'fourth wave' of CBT developing. It is difficult to give precise dates for these stages but it is possible to mark out periods when each stage began to emerge. Significant developments of CBT have occurred in the United States, the United Kingdom and in other countries. Sometimes these developments have been relatively independent of each other whilst at other times there has been marked synchronicity and cooperation.

Behaviour therapy emerged during the period 1950 to 1970. In the UK, behavioural therapy was more influenced by the theories of Pavlov, Watson and Hull. Wolpe (1958) and Eysenck (1960) played significantly roles in developing therapeutic interventions based on these ideas. In contrast, behaviour therapy in the US was more influenced by the operant conditioning theories of B.F. Skinner and this especially showed itself in the development of 'token economy' regimes for especially disturbed psychiatric patients (Ayllon & Azrin, 1968). Wolpe's (1958) work was centred on fear-reduction techniques

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[2] I am aware that there are different conventions in the use of terminology regarding these various therapeutic models.

for anxiety disorders. The theoretical issues connected to neurotic disorders were of particular interest to him and to Eysenck and they were both keen to attack psychoanalytic approaches. The Maudsley Hospital and the Institute of Psychiatry, both in London, were centres for the development of behaviour therapy. Neither centre was involved with long stay patients so that there was less interest in the 'token economy' approaches that had been developing in the US. British behavioural therapists therefore tended to follow the focus of Wolpe (1958) and Eysenck (1960) on the anxiety disorders, especially to agoraphobia. Anxiety problems were defined in strictly behavioural terms and this led to treatments using 'systematic desensitization' and 'exposure' (Wolpe, 1958), which began to achieve clinically significant results and thereby generated what Rachman (1997b, p.7) refers to as 'un-British levels' of enthusiasm.

Unlike American behaviour therapy, however, behavioural therapy in the UK was always less influenced by the 'radical behaviourists', such as the Skinnerians. Rachman (1997b, p.6) characterises British behaviour therapy as, "... a qualified environmentalism in which neurotic disorders were regarded as the product of environmental events, learning experiences, and conditioning in particular..." There were certainly major conflicts between behavioural psychologists and 'medical model' psychiatrists in the UK (Meyer & Chesser, 1970) but *some* psychiatrists *were* involved in developing behaviour therapy. This was not the case in the US. Clinical psychology was a new emerging profession at this time and used the new behavioural approach to demarcate an area of expertise for itself.

Despite these differences between the British and American contexts, there was also much common ground and developments began to cross-fertilize and cohere as this period went on. Like many other 'movements', however, behaviour therapy began to hit certain more intractable problems of development also. The theoretical unity of the approach began to suffer as clinical researchers became more remote from psychology researchers. The latter were beginning to show that even simple Pavlovian conditioning was more complicated than had been thought (Rescorla, 1986). There was also a pervasive belief that findings based on animal research could not be transferred

automatically to human contexts. There was a kind of 'dryness' in traditional behavioural empiricism that did not allow even speculation about what other mechanisms, other than those that were observable, might be involved in psychopathology. Finally, existing behavioural treatments began to reach the outer limits of their applications. The treatment of depression was one area where behavioural approaches had not proved especially effective and the fact that Beck's Cognitive Therapy developed specifically for depression opened a door that was attractive to many existing behaviour therapists.

Cognitive therapy emerged as a distinct therapeutic model from the mid-1960s onwards. It might at first be thought that cognitive therapy could prove a considerable jump for behaviour therapists, especially in certain theoretical features such as the reliance of the patients' self-reports. In fact, as behaviour therapy had expanded to more areas it had begun to consider the role of cognition anyway: thought, for example, could be defined as a 'covert behaviour' (Cautela, 1967). Previously forbidden areas of internal functioning were now opening out for behaviourists. The theoretical principles of cognitive approaches are covered in Chapter 2 but at this point it should be noted that, although stressing cognitive factors in the development and treatment of psychological problems, both Ellis and Beck, its earliest proponents, also stressed the importance of behavioural change. Ellis (1962) specifically argued that insight was not enough for effective change, which had to be secured by behavioural change. The Beckian tradition also stressed the role of behavioural experiments in the change process, though it tended to define these experiments in cognitive terms. A client who believed that he couldn't stand the embarrassment of failing in public might, for example, be induced to devise an experiment during which he did 'fail' in public, in order to find out if he *could* stand it.

Another feature of Beck's cognitive therapy that was attractive to behaviourists was the emphasis on empirical outcome learnt from behaviour therapy research. The early results of the cognitive therapy of depression were sufficiently strong to cause intense interest in the therapeutic community (Weishaar, 1993). The success of the early trials was not completely replicated in the large scale NIMH trial during the 1980s. Paradoxically, cognitive methods have had a stronger impact on the anxiety disorders, which were

originally the preserve of behaviour therapy (Clark, 1986: Barlow, 1988). In its turn, newer attempts to find a behavioural formulation and treatment of depression have also proved much more successful (Jacobson & Hollon, 1996a; 1996b). These crossovers proved the potential scope for collaboration, integration even, of the behavioural and cognitive therapies.

The CBT 'fusion' was perhaps signalled when the British Association for Behavioural and Cognitive Psychotherapies (BABCP) presciently formed itself in 1972. This was before the term 'cognitive behaviour therapy' was in common use: the earliest usage I have been able to find is that of Mahoney (1974) and Meichenbaum (1977), who referred to 'cognitive and behaviour modification' and 'cognitive-behavioural modification' respectively. Rachman (1997b, p. 18) sees the main fusion starting from the late 1980s onwards:

> It is possible to discern an exchange, in which cognitive concepts were absorbed into behaviour therapy, and cognitive therapists attached increasing importance to behavioural experiments and exercises.

I referred earlier to the 'dryness' of traditional behavioural theory lying in its unwillingness to look for content that supplies underlying constructs that might bolster behavioural approaches. Beck (1976) had speculated that he would find specific cognitive content for other psychological problems as he had for depression, the 'cognitive specificity hypothesis.' Much research has now been completed by many research groups and has indeed begun to supply much valuable information about the cognitive content and processes of not only well known areas such as anxiety and depression but also areas such as eating disorders and even personality disorders (Salkovskis, Ed., 1996). Thus, as Rachman (1997b, p. 18) puts it, 'Cognitive therapy is supplying content to behaviour therapy.' Even here there could be danger, in that therapists might take up research-based formulations too readily without taking enough account of idiosyncratic client factors.

By the late 1980s, whilst exciting new and confirmatory evidence about cognitive approaches to the anxiety disorders, especially panic disorder emerged, some of the conceptual framework of the approach to depression was being increasingly questioned. The schema concept, though plausible, was proving very difficult to operationalise and

test: especially the notion that depressogenic schemas were dormant vulnerability factors. Research failed to show evidence of such schemas in recovered patients, raising the suspicion that they might be 'mood dependent' and thus impossible to show as causative factors for such moods. Teasdale (1993) added a powerful critique by suggesting that much of the relevant cognitive processing in depression was non-conscious and was not therefore not easily accessed by then current cognitive techniques.

It has, however, been a characteristic of CBT that it has been relatively open to criticism and has regularly revised its theories and methods. Part of the response to Teasdale's critique was a revision of the concept of schema (Beck, 1996; and Teasdale, 1996). This revision was itself related to wide recognition that the relationship between emotion and cognition is highly complex and certainly not a linear one. It is often difficult to discern the effect of a cognitive intervention because little is really known about the time sequence of intervention effects. Whilst some cognitive interventions seem to work quickly, others may need time to 'work through'. Indeed, there may be something unconvincing about rapid cognitive change. One of the few remaining sharp debates between behaviour therapy and cognitive therapy has been about whether cognitive interventions really add anything to the outcome of exposure treatment. Network theories of emotion and cognition are emerging: suggesting that there are many different firing order relationships between emotion, cognition, physiology and behaviour (Teasdale, 1996).

Cognitive content is only one part of the active processes in psychopathology. The attention process is increasingly seen as an area to target in CBT. In OCD (obsessive-compulsive disorder), one of the most intractable anxiety disorders, for example, the thought content of OCD patients does not differ significantly from non-patients. The decisive factor seems to lie in the way patients pay obsessive attention to those thoughts (Wells, 1997). Similarly, the content of worrying thoughts in GAD (generalised anxiety disorder) patients is the same in non-patients as in patients. Patients, however, attend to these worries differently and this results in rumination (Leahy, 2005). Recent developments in CBT owe something to Buddhism in that therapists have encouraged

clients to pay 'mindful awareness' to such thoughts in order to defuse the effects of negative attention. This may seem to be quite distant from the original methods of CBT but, nevertheless, mindfulness has been subjected to outcome scrutiny and early results seem promising (Segal et al, 2002). Some people have even discerned a 'fourth wave' of CBT building up in these developments (Hayes et al, 2004). CBT has shown little tendency to stay still for long so far so it does seem likely that there will a fourth wave at some stage. One enduring criticism of CBT has been that it has not addressed the issue of emotions in therapy as thoroughly as is required (Greenberg, 2002). All the new developments in CBT seem to be pointing at the area of new models of understanding and changing the relationship, increasingly appreciated as complex, between cognition, emotion and behaviour.

1.3: Personal Motivation for the Study

I have been interested in Cognitive Behaviour Therapy since the early 1980s when I first read Beck et al's book *Cognitive Therapy of Depression.* I was then a social work educator with a background in behavioural methods. I became more familiar with CBT methods after training as an Alcohol Counsellor in 1984, a Rational Emotive Behaviour Therapist (REBT) in 1992 and a Cognitive Therapist in 1994. As I learnt and practised these cognitive-behavioural methods, I became more and more personally comfortable with them and I also found that I began to achieve more concrete and satisfying results with clients. At the same time, I was getting more involved in training for counsellors and therapists and, in 1988, secured a full time University post organising and teaching on a programme of counselling training courses.

Some students seemed quite hostile and suspicious of the CBT model and this was usually couched in terms of its incompatibility to the concepts of other models: most usually the 'client-centred' nature of Rogers' model and somewhat less frequently by the psychodynamic objection that CBT only deals with the surface of the problem and ignored the problem's supposed deeper roots. Sheldon (1995) describes teaching the CB approach to social workers as operating "in a cold climate" (p.5) due to the tendency of some social work students to avoid the CB approach on "vague philosophic grounds –

aesthetic grounds might be a better phrase" (p. 31). Other writers too have observed that counsellors and psychotherapists may hold these reservations about the model quite frequently (Dryden, 1998; Persons et al, 1996). Rachman notes, even behaviour therapy 'lead to quite un-British excitement' within the UK psychiatric field. Beck (1996) considers that cognitive therapy has always been well received in the UK, at least within the psychiatric field. This may be a mixed blessing for CBT as there has been an anti-psychiatry movement in both counselling and social work, and CBT may seem to some to be 'guilty by association' with psychiatry.

My interest in the research area described above came from these experiences. I began to wonder if certain attitudes concerning therapy prevented some trainees from engaging in learning CBT either by preventing the development of a motivation for learning and/or by putting more specific blocks in the way of learning specific concepts and in turn undermining the learning of CBT skills. I decided to put these notions to the test.

1.4: Organisational and Policy Factors that May Influence the Process of Training

Trainee responses to any educational process are likely to be influenced by the age, gender and previous educational achievement of the trainees. Data concerning these factors were collected and analysed as part of this study. It is also important to acknowledge that therapeutic activity takes place in a social context – in this case, one that relates to systems of provision of therapeutic services, involving both the public and private sectors.

The modern history of the development of psychological therapy, described earlier in this chapter, began in the field of private practice: the consulting rooms of Freud's own home. Freud, however, had links with the University in Vienna and psychoanalytic practice quickly spread into the hospitals via the University professors of medicine and psychiatry. Jung, for example, was a doctor within the Burgholzi Mental Hospital, attached to the University of Zurich. The public provision of psychological therapy grew only slowly in the UK and USA even after World War II. In the last two decades of the 20th century demand for therapy services rose but all forms of public service provision

were increasingly scrutinised for evidence concerning the outcomes of provision. In the 1990s in the USA the system of Managed Care developed in both general medicine and mental health services (Hoyt, 2000). There was a coincidence of interest between both the health insurance companies and public health agencies to contain costs in the provision of health care and mental health care services. This resulted in a situation in which some agencies and companies would only provide funding for psychological therapy where there was a clearly diagnosed condition, in the case of mental health, as defined in the Diagnostic and Statistical Manual (DSM.; American Psychiatric Association, 2000) that could be matched with an empirically supported treatment (EST). In 1995, the Clinical Psychology Division of the American Psychological Association identified a number of psychological interventions as empirically supported. Cognitive behavioural approaches constituted the majority of these ESTs (Chambless & Ollendick, 2001; Herbert, 2003; Sanderson, 2003). The identification of specific forms of effective therapy diverged from a well-known trend in psychotherapy research, the so-called 'Dodo Bird' trend that claims all therapies are nearly equivalent in effect (Castelnuovo et al, 2004). The empirical claims of CBT have led to some hostile reaction from proponents of other models. Such claims may therefore act as a double edged sword in the process of disseminating CBT: they may attract some potential trainees but repel others.

In the UK, government reports and mental health policy documents started to use the language of evidence based mental health (Roth & Fonagy, 1996; Parry & Richardson, 1996; Dept of Health,1999) culminating in the provision of advice leaflets to GPs regarding therapies of choice - in which CBT featured prominently. Since 2006, these policy factors have been accentuated by the proposal from the Labour peer, Lord Layard, to greatly increase access to psychological therapy, especially to CBT (Roth & Pilling, 2007). There are currently ambitious training plans to expand CBT training. This policy planned expansion has important implications for trainees and trainers and these will be discussed in the conclusion to the study in Chapter 7. This present study therefore sought to find if these policy and employment influences were evident at individual employment level: for example, were employees in NHS mental health settings being encouraged to

undertake training in CBT as a prominent example of evidence based practice? Were trainees motivated by the perception that they might enhance their career prospects by learning CBT skills?

CBT has been highlighted in other public services as well – including Probation (McGuire, 1995) and Social Work (Sheldon, 1995). The study was also concerned to establish how widely the influence of CBT was experienced in professional agencies generally and whether this might be linked to individual perceptions of training needs. Durkheim (1952) advised against making 'psychologistic' assumptions about human behaviour. Such assumptions might prove over-individualised explanations of behaviour that discount the influence of sociological influences. Consideration of the social and employment processes will be augmented by the examination of the post-training work environment. Ashworth et al (1999) followed up CBT trainees in the NHS three years after training and found that many of them had already been promoted into management positions where they no longer saw clients in face-to-face clinical work.

1.5: Research Aims and Questions

The study aimed to answer the following research questions:

- What attitudes do trainees entering a CBT training course hold towards CBT practice principles and how do these attitudes develop during training and in the year following the end of training?
- With what level of pre-existing competence in performing the skills associated with CBT practice do trainees enter CBT training and how do these CBT skills develop during training?
- What kind of association and influence do the attitudes towards CBT principles held before and during training have in the development of competence in skills associated with CBT practice?
- What characteristics of CBT training and development do CBT trainees report as being most likely to lead to the resolution of difficulties in learning CBT during training?

It was hypothesised that attitudes reflecting reservations about CBT theory or practice might be held by some trainees entering training with strong allegiances to other models and that these attitudes might change during training. It was hypothesised that strong resistance to change mig inhibit certain types of skill development. The longitudinal nature of the study offered some prospect for exploring how far attitude change might be retained after training and gave trainee chance to reflect on what aspects of training, practice and employment might enhance change a maintenance of change.

1.6: Relation to Theory

Piaget (1950) suggested that information processing is accomplished by the joint processes of assimilation and accommodation. Assimilation refers to the reception and acceptance of sensory material. Accommodation is the difference made to the mind by assimilation. The processes of assimilation and accommodation result in adaptation: the way humans have of orientating themselves to information in the world. This is represented in the mind by sets of schemas. Piaget developed the concept of schema from Bartlett (1932), whose work established that certain perceptions might be assimilated into the mind in a way influenced by pre-existing schema. Piaget extended this idea into his studies of intellectual development in children. For example, a young child might physically see a dog but might not yet have a schema of 'four-legged ness' and so might not fully perceive it as a four-legged creature. Accommodation, a more convinced organisation of information into more permanent forms of knowledge - depends on the development of more permanent knowledge structures.

This study begins with the assumption that trainees may approach CBT courses with a range of different schemas about psychological therapy and these schemata may be evident in various therapeutic principles and attitudes. Furthermore, these schemas may influence the way that trainees assimilate the new concepts from CBT theory and practice. Pre-existing schemas about therapy may also influence the process of adaptation to new schemas related to CBT principles and attitudes. One hypothesis that was tested in this regard was that where trainees come to training with therapeutic attitudes and schemas that are very different to equivalent concepts in CBT, the process of adaptation

may be delayed or distorted. A further hypothesis was that CB skill acquisition may also be aversely effected by these delays and skews.

When a person is attempting to assimilate new ideas with older ones, that person may experience 'cognitive dissonance' (Festinger, 1957). Cognitive dissonance refers to the experience of holding two or more contradictory ideas at the same time. Festinger's concept has spawned a considerable literature (Atherton, 2003). Many studies have confirmed that the experience of dissonance tends to motivate people to seek new syntheses of meaning, though dissonance may be maintained over quite long periods (Atherton, 2003). Periods of dissonance are very evident in many of the Socratic dialogues (Neighbour, 1992; Nehemas, 1998). The term *aporia*, of Greek origin, has been used to describe the state of experiencing dissonance. The ancient meaning of *aporia* relates to being at a river with no crossing point (Nehemas, 1998). The term is now used by philosophers to indicate a gap in knowledge. Later discussion will consider whether the experience of dissonance in training may be an unavoidable and perhaps even desirable stage of learning new ideas.

Aronson & Pratkanis (2001) suggest that people with dissonant ideas tend to move towards new syntheses that maintain their view of themselves as rational and social beings. It was quite likely therefore that the trainees in this study, especially those with training in a different therapeutic model, would be likely to report cognitive dissonance as a reaction to training in CBT. They will also be likely to report different degrees and experiences of moving towards new syntheses of old and new therapeutic principles. There could also have been evidence of syntheses that reflect the maintenance of self-concept. Atherton (1999), reporting on professional training, suggests that professionals who have invested effort in training are likely to claim value for the training because to admit otherwise would imply that one had been tricked or sold short.

To some extent, the ideas of assimilation and dissonance during training assume that an influencing process is present in any training situation. The processes of influencing other people have been extensively studied in social psychology. For example, Petty & Capiocco (1981; 1986) have distinguished between peripheral and central change

processes. Attitudes gained by peripheral processes are quite amenable to change, often via relatively unsubtle influencing processes such as persuasion. New attitudes reached in this way, however, may be short-lived and may not show much resilience when challenged. Attitudes resulting from effortful central processes, however, are more resistant to change via influencing and are generally most likely to change by a process of elaboration likelihood. The elaboration likelihood model (ELM) model suggests that a situation in which the learner is able to consider new ideas as against old ideas and is given relative freedom to 'play' with new sets of ideas is more likely to result in them being able to reach a convincing personal accommodation. The probability of elaboration likelihood is increased when: 1) the person has the capacity to elaborate attitudes, 2) the person is motivated to elaborate attitudes, 3) thoughts favourable to a new attitude predominate in the person's mind, and 4) thoughts favourable to the new attitude are stored in long term memory (Heesacker & Meija-Millan, 1996). It is important to note that peripheral and central cognitive processing occur on a continuum. A strongly held attitude can serve as a peripheral cue for assessing another attitude (Petty & Krosnick, 1995). The ELM has been applied to psychological therapy (Heesacker & Mejia-Millan, 1996) but not yet to training in psychological therapy. Elaboration likelihood may be enhanced by the values of adult education theory as advanced by writers such as Knowles (1984). Knowles suggested that successful adult learning is characterised by andragogy – including especially self-directedness, resourcefulness for learning from life experience, motivation from tasks required for performance of social roles, and problem-centred learning. Cassidy (2004) found that psychiatric residents in Canada reported such an approach to wanting to learn CBT as part of continuing medical education. Merriam (1993, 2001), however, suggests that the principles of the 'andragogic' orientation are context specific and may not, for example, be appropriate for certificated learning. Psychiatric residents may, for example, regard themselves as having attained their primary professional identity and may see CBT as 'additive' learning (Atherton, 1999).Trainers in certificated learning usually exercise control over the processes of curriculum implementation and training course management. Data from all kinds of learners certainly suggests the presence of a pervasive sense of anxiety about assessment and the achievement of qualification by trainees (Baxter Magolda, 1996; Clarkson, 1994).

Tight (2002) also reviews Knowles' work in light of subsequent adult learning theory. He suggests that the andragogy concept never completely transcended Knowles' own value base but nevertheless played an important role in the development of a unique educational approach to the learning needs of adults. Along with concepts such as the reflective practitioner (Schon, 1983) and the experiential learning cycle (Kolb, 1984), the andragogy concept has helped to shape such contemporary adult learning methods, such as experiential learning, reflective practice and problem based learning. Experiential learning has been widely taken up in counselling education (Johns, 1996). Problem based learning has been influential in social work education (Burgess & Taylor, 2005) and has been used in clinical psychology (Huey, 2001) and CBT training (Myles & Milne, 2004). Adult education approaches to training in psychological therapy are further reviewed in Chapters 3.and discussed in Chapters 6 & 7.

1.7: Methods of data collection and analysis

This section will describe the main research methods used in the study. Data collection followed a strategy based on survey design. The methods used to gather data regarding trainees' experiences during training were:

- Questionnaire
- Interview
- Assessment of competence using a validated scale

The data were analysed with regard to the research questions presented in 1.5, especially concerning the characteristics of trainees, their perceptions of CBT training and the development of competence during training. Because the study required data to facilitate understanding of teaching and learning processes over a considerable period of time: between 2 –3 years covering the pre-training period, the training period and the post-training period – the study design is longitudinal, involving 'panels' of participants and repeated measures (de Vaus, 2001).

A questionnaire, the Cognitive Behaviour Therapy Training Questionnaire (CBTTQ), including a Cognitive Behaviour Principles Inventory (CBPI), was developed to measure

the trainees' beliefs systems and their compatibility with the principles of CBT (Beck & Emery, 1985; Beck, 1995). The questionnaire also asked a number of questions about the social and employment aspects of training: for example, the degree of training support from employers. This questionnaire was administered just prior to the commencement of training, at the end of the training course and at one-year follow up. The aim of this questionnaire was to get broad, quantitative data. At its final administration, respondents were asked if they would be willing to participate in a semi-structured interview.

The aim of interviews was to gather narrower, more qualitative data from what was assumed as likely to be a smaller sample. Having sources of quantitative and qualitative data both bearing on the same training processes offered the possibility of triangulating different types of data, thereby examining the same phenomena from different angles (Bryman, 2004). A decision was made to interview only those trainees who had finished the programme of studies – which included a period of research after the CB training – one year after the completion of all studies. This decision was made in order to limit the effect on 'social desirability' factors that may have been linked to trainees being interviewed by a person involved in the course teaching team. Trainee acquisition of CBT skills was measured using a standardised CBT competence measure (Milne et al, 2001). The questionnaire data were analysed using the SPSS programme, 14th Edition, and analysis focussed on describing the structure and content of trainees' initial therapeutic principles and how they developed over the period of the study. Analysis was also made of employment factors to determine if different agencies exert influence over motivation for training and for practice. The semi-structured interview was developmental in nature and gathered retrospective data about the training experience and prospective data on expectations about the future. A number of areas overlapped in the questionnaire and interview schedule, allowing for crosschecking of information given at different points of time and triangulation of quantitative and qualitative data bearing on the same research questions. The research design and methods will be more fully described in Chapter 4.

1.8: Conclusion to Chapter 1

The study aimed to build a solid picture of trainee characteristics, training processes and the social and employment context in which they operate, allowing consideration of the most effective combinations of these factors in successful training outcomes. The findings are reported in Chapters 5 and 6 and their implications are discussed in Chapter 7. During the life of this research, the UK government announced a programme to expand CBT training so the policy implications of this research for therapy training and provision will be discussed.

Other research has covered some of the ground covered in this study but new factors give greater depth to this study. These new factors lie in its longitudinal nature, the measurement of the development of attitude development over time, the measurement of skill learning and development and the consideration of trainees' views on what helped overcome difficulties in training. As Freiheit & Overholser (1997) note, lack of focus on skill acquisition has been an important gap in previous research:

> The present study is limited by having only clinical graduate students as subjects, and relying on a self-report measure to assess frequency of using cognitive and behavioural techniques. Without confirming evidence from observation or reports from clinical supervisors, it is difficult to determine the accuracy of self-report usage of cognitive-behavioural techniques. Moreover, the proficiency of using cognitive-behavioural techniques as trainees was not assessed. Because students had different supervisors, the utility of competency-based scores would have been questionable. ***Future research may want to address whether trainees from other orientations become as competent at using CB techniques as trainees with a CB bias*** (Freiheit & Overholser, 1997, p. 85, *Bold italics added).*

CHAPTER 2: The Principles and Practice of Cognitive Behaviour Therapy

Take no enterprise in hand at haphazard or without regard to the principles governing its proper execution... Make your rules of life brief, yet so as to embrace the fundamentals: recurrence to them will suffice to remove all vexation... (p.63)
... In the management of your principles, take example by the pugilist, not the swordsman. One puts down his blade and has to pick it up again; the other is never without his hand, and so needs only to clench it (p.182).

Marcus Aurelius, *The Meditations.* (Oxford University Press, 1989)

This chapter critically examines the principles of CBT and the model of practice derived from them. It will pay particular attention to features of the principles that are likely to increase or decrease trainees agreement with and adherence to them. In some cases, the ability to adhere to the principles of CBT will be affected by adherence to previous models of practice (Persons et al, 1996). The emphasis on assimilation and accommodation in the processing of information whilst learning CBT reflects some aspects of the process of the CBT model itself.

According to the Shorter Oxford Dictionary (Onions, 1973, p. 1585), the word 'principle' has three meanings: 1) 'origin, source', 2) 'fundamental truth, law or motive force', 3) 'rudiment or element'. Many applied subjects use the expression 'principles and practice' in the second meaning. A set of principles, derived from a parsimonious set of axioms, is described and linked to practical steps involved in their implementation. Training in the application of a subject is often structured round the teaching of principles and practice of their implementation. Beck (1976), Beck & Emery (1985), Beck (1995), and Alford & Beck (1997) describe an evolving set of principles regarding the nature and implementation of cognitive therapy. Beck's cognitive therapy has already been located within the evolution of the wider school of CBT. The purpose of this chapter is to describe and critically examine the principles described by Beck and his colleagues. This is an important step in the overall rationale of this thesis because the thesis focuses on how groups of trainees in CBT were able to learn these principles and the extent to which they were able to implement them in practice. The principles will be critically reviewed in their own right and also by comparison with the theoretical and practical principles of

other approaches to psychological therapy. As was noted in Chapter 1, trainees will frequently be influenced by these other principles.

The introductory chapter explained how multiple approaches emerged within the field of psychological therapy. Beck (1976) claimed that cognitive therapy had come of age and had "warranted admission to the arena of controversy" (p. 7) alongside other approaches to psychological therapy. Beck has frequently argued that the admission of Cognitive Therapy to this wider field was warranted by the fact that it could claim to be:

> ... a system of psychotherapy which provides (1) a comprehensive theory of psychopathology that drives the structure of psychotherapy, (2) a body of knowledge and empirical findings which supports the theory, and (3) research findings that demonstrate its effectiveness (Weishaar, 1993, p.47).

The principles of CBT were first discussed in general form by Beck (1976). These principles were then presented as a series of statements of principles by Beck & Emery (1985) and were again discussed by Beck (1995) and Alford & Beck (1997). The clearest statement of them is by Beck & Emery (1985), who formulated these principles as 10 separate statements:

1) Cognitive therapy is brief and time-limited.
2) Cognitive therapy is structured and directive.
3) Cognitive therapy is problem and goal-oriented.
4) Cognitive therapy is based on an educational model.
5) Homework is a central feature of cognitive therapy.
6) Cognitive therapy uses primarily the Socratic method.
7) The theory and techniques of cognitive therapy rely on the inductive method.
8) A sound therapeutic relationship is a necessary condition for effective cognitive therapy.
9) Therapy is a collaborative effort between therapist and patient.
10) Cognitive therapy is based on the cognitive model of emotional disorders.

Each principle will be described in turn. The rationale for each will be explained, and research and other evidence pertaining to it will be explored. The description of each

principle will be concluded by consideration of how it might relate to equivalent principles in other therapeutic models. Some principles, such as 8 and 9, offer less potential for differentiation from other therapy models and will not therefore be described in equivalent length to others. Other principles, especially 1, 2 and 10, are highly significant in their contribution to the theoretical basis of CBT. They intrinsically differentiate the beliefs associated with CBT from those of other schools. These principles will therefore be covered at greater length than others. The chapter will conclude by describing how CBT principles are reflected in currently used CBT skills inventories.

Beck's work began as an approach to treating depression and was then also applied to anxiety. Applications of CBT have now spread into many different areas. CBT theory and practice, however, are still most clearly established and tested in the treatment of anxiety and depression. This review will therefore use examples from these two areas. The final principle of the importance of formulation in CBT will be illustrated by its' application to Panic Disorder, one of the anxiety disorders as defined in DSM-IV TR (APA, 2000).

2.1: Principle 1: CBT[3] is brief and time limited

> Just as he (Beck) was completing his analysis, they (Beck and his wife) were attending a meeting of the American Psychoanalytic Association, where they spotted a sign outside a lecture hall reading 'Symposium 15: Problems of re-Analysis.' Beck recalls Phyllis' reaction. "What!" she exclaimed, "re-analysis? You mean you have to go back and get re-analysed? That's crazy!" Beck claims that her opinion helped crystallise his own thoughts, for after two and a half years of analysis, he hadn't noticed any changes (Weishaar, 1993, pg.19.)

> Cognitive therapy of anxiety is a time-limited, problem-focused approach to treatment based on the cognitive model of anxiety disorders (Wells, 1997, p.42).

2.1.1: Defining short-term and long-term therapy

Any current discussion of time limits in psychological therapy has the inherent difficulty that stems from the relativity of the terms 'long-term' and 'short-term'. In practice, a consensus has developed around pragmatic definitions that would identify a continuum

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[3] The use of the terms 'cognitive therapy' and 'CBT' follow the statement made on page 12, and follow the usage of Hawton et al (1989) and Rachman, (1997b).

where the 'short-term' end would be defined as being 20 or fewer one-hour sessions and 'long-term' as being therapy of a duration of one year or more - approximately 40 or more such sessions - (Ivey et al, 1997). The expression 'medium term' is sometimes used to describe therapy of between 21 and 39 hour long sessions. The relativity of the terms is, however, evident at all points of the continuum. CBT for Panic Disorder has been defined as being available in a package of as few as 5 sessions (Clark, 1996; Botella & Garcia-Palacios, 1999). Some authors claim that certain other therapies can be practised in potentially single session formats: for example, Eye Movement Desensitisation and Reprocessing (EMDR) (Shapiro, 1995), solution-focussed brief therapy (O'Connell, 2001). The majority of counselling interventions in current UK primary health care settings and in employee assistance counselling is conducted over 6-8 sessions, usually with special permission being needed to go over this limit (Parry & Richardson, 1996: BACP, 1998). At the other end of the continuum, psychoanalytic therapy may be conducted 3 or 4 times per week for up to 10 years (and more), giving a potential for over 2,000 sessions. The psychoanalyst, Winnicott, for example, is described as having attended more than this number of sessions as part of his training analysis (Grolnick, 1991). The length of traditional psychoanalytic treatment led Rogers (1967) to regard his model of client-centred therapy as being 'short-term' when the same volume reveals that Rogers frequently refers to working with clients for between 80-100 sessions.

There has been a major contextual change in the last 20 years in that psychological therapies have gradually moved into the mainstream health systems of Britain and USA. At a time when both the central government and insurance based welfare funding sources that pay for these systems have been subject to constant review (Cummings & Sayama, 1995) this has meant that the therapies have had to contend with a "socio-economic climate that values shorter treatments and demonstrated efficacy" (Weishaar, 1993, p.141).

Studies of psychological therapy developed a more rigorous approach to outcome from the 1970s onward. They have tended to show that, for most clients, change begins relatively early in therapy and is enhanced by long-term interventions only in some cases

(Ivey et al, 1997; Cummings & Sayama, 1995). Reviewing a wide variety of psychological interventions, Sheldon (1995) concurs with this view and describes the 'decreasing marginal utility' of therapy over time and for social work, advocates 'short intensive' interventions. (p.16). The short-term nature of Beck's Cognitive Therapy is first described in the seminal 1979 publication on the cognitive therapy of depression (Beck et al, 1979) in a chapter describing the typical course of therapy. This typical course is defined as 20 sessions held over 15 weeks. It is noted that it is often helpful for the depressed patient to have two sessions per week during the initial phase of the therapy but this can be dropped to one session per week after 3-4 weeks.

2.1.2: The rationale for short-term therapy

Whilst an early pattern in therapy of 2 sessions per week is justified by the idea that critical therapeutic mass is needed to achieve initial symptom relief, no overall detailed rationale for the general length of therapy is offered in Beck et al's (1979) work. If anything, the implied rationale is an empirical one, based on research studies on implementing the CBT structure in which the average number of sessions turned out to be 15 (Beck et al, 1979). Nonetheless this pattern seems to have set the norm for the length of standard CBT. Most subsequent definitions of typical length have taken 20 sessions as the upper limit. There has been some variation according to the problem area being addressed: in general the number of sessions for the treatment of anxiety disorders has been set slightly lower than other areas, especially depression.

A more detailed and rationale-giving discussion of the short-term nature of cognitive therapy is given in the consideration of CBT principles in Beck and Emery (1985), who describe its application to anxiety disorders. The authors offer the same pattern of sessions for the treatment of anxiety as that for the treatment of depression (Beck et al, 1979) - twice weekly treatment for a short period followed by weekly sessions up to 20. The need for the number of sessions to match individual problems and patterns is acknowledged: so that specific anxieties may be treated in fewer sessions and individual patients may require extra time. The spirit of this aspect of cognitive therapy, however, is indicated in statements that, "Long-term therapy for anxiety is unnecessary and is, in

many cases, undesirable." (p.171), and, "... the pace of therapy is relatively brisk." (p.171).This short-term emphasis contains a meta-message to the patient that problems are capable of solution.

It is suggested that the therapist "rushes slowly" (p.171) and this implies covering important areas but being able to "move on quickly" (p.171). Such important areas might be background history and the exploration of original causes. Beck & Emery (1985) suggest that the exploration of such material be kept to a minimum. As these areas are strongly emphasised in psychodynamic therapy, psychodynamic therapists are often critical of this aspect of CBT (Persons et al, 1996). Beck & Emery (1985, p.172) offer a number of other supplementary guidelines and encouragements for keeping cognitive behaviour therapy time-limited:

1) Keep it simple.
2) Make treatment specific and concrete.
3) Stress homework.
4) Make on-going assessments.
5) Stay task-relevant: Discussing religious, spiritual or philosophical beliefs, if not pertinent to the patient's main concern, prolongs therapy. If the patient insists on such discussions, the therapist can point out how it distracts from the main business of therapy.
6) Use time-management techniques: e.g., setting an agenda for each session.
7) Develop a brief-intervention mind-set.
8) Stay focused on manageable problems.

It may be noted that the development of 'a brief intervention mind-set' amongst trainees reflects a key area of concern for this study. The business-like spirit evident in the list of points above is somewhat less emphasised in the parallel set of principles given by Judith Beck. Judith Beck (1995, p.7) comments:

> Cognitive therapy aims to be time limited ... (but) ... not all patients make enough progress in a few months. Some patients require 1 or 2 years of therapy (possibly longer) to modify very rigid dysfunctional beliefs and patterns of behaviour that contribute to their chronic distress.

2.1.3: Long-term versions of CBT

Judith Beck shows a slight shift in emphasis on the question of time limits by changing them from a given to an aim. This may have resulted from CBT refashioning itself

somewhat to appeal to a wider range of counsellors and therapists (Persons et al, 1996). If we examine CBT as a social and therapeutic 'movement', it may be that in its early years it was concerned to differentiate itself from the other therapies that were on offer. When it came to be regarded as a significant player – 'warranted admission into the arena of controversy' in the words of Alford & Beck (1997, p.7) – and no longer needed to establish its identity, it may be that it has been able to take a less rigid view of certain principles. The slight softening on the principle concerning length of therapy may have occurred because of the emergence of the 'schema-focused therapy' model (Young et al, 2003). Young et al (2003, pp 2-4) describe how the evolution of schema focused therapy began as they found that the following assumptions underlying the 'standard model' of cognitive therapy did not fit a significant minority of patients with more difficult problems:

1) Patients have access to feelings with brief training.
2) Patients have access to thoughts and images with brief training.
3) The patient has identifiable concerns on which to focus.
4) Patients are motivated to do homework assignments and learn self-control strategies.
5) The patient can engage in a collaborative relationship with the therapist in a few sessions.
6) Difficulty in the therapeutic relationship is not a major problem focus.
7) Cognitive and behavioural patterns can be changed through empirical analysis, logical discourse, experimentation, gradual steps and practice.

When these assumptions are not met, therapy is likely to last longer than the 20-session limit. Some critics have considered that there has been a 'psychoanalytic drift' inherent to cognitive therapy (Milton, 2001, p.441). The development towards a more open-ended and longer version of CBT may be taken as evidence for this 'drift' and could threaten the parsimony of the initial model.

2.1.4: Length of therapy and efficacy

There has been comparatively little research into the effects of different lengths of psychological therapy (Roth & Fonagy, 1996). This is perhaps surprising given the socio-economic imperative towards briefer work. A large cost benefit analysis was conducted as part of the Kaiser Permanente longitudinal studies, run over 25 years between 1960s and 1980s (Cummings, 1977; Cummings & Sayama, 1995). The results showed that, for

most, i.e., around 85% of clients, much of the measurable benefits of therapy were achieved in the first 10 sessions and a noticeable trend of 'diminishing returns' was evident thereafter. This might be taken as a straightforward rationale for brief therapy. There were, however, also smaller groups of clients, around 10%, for whom middle range number of sessions, i.e., around 20 or over, is the most effective 'dose size' and, finally, the other 5 % may need much longer-term therapy.

One gets the impression that the landscape of practice has shifted so much that almost all recent research is conducted by estimating the outcomes of relatively brief therapy of all types (Cummings et al, 1998; Cummings & Cummings, 2000). It is interesting to note that there has been a shift towards briefer psychodynamic models (Malan, 1976; Della Selva, 2004). Roth & Fonagy (1996), for example, report on brief dynamic therapy for depression: in a mode of 12 session treatments (range 12-36). This type of model has been used in clinical trials as the alternative treatment condition to CBT, against which it generally recorded less symptom reduction (Andrews, 1999; Hollon et al, 1996), though in some studies it has performed equally in this and other respects (Milton et al, 1999).

Interpersonal therapy (IPT), a brief protocol-based dynamically orientated treatment (Weissman et al, 2000) was devised as an alternative treatment method to cognitive therapy in the large NIMH trials in the late 1980s. It performed as well as cognitive therapy in many aspects and is now regarded as a treatment of choice, alongside CBT, for many types of depression and eating disorders (Roth & Fonagy, 1996).

Cummings & Sayama, (1995) suggest another compelling issue for therapists exploring the idea of 'dose size'. They suggest that therapists should question their assumptions about whether therapy should be continuous. The data from the Kaiser Permanente studies suggests that, especially for clients with longer-term needs, a 'general practice' model may be more relevant than weekly sessions. Such an approach is defined as "brief intermittent psychotherapy throughout the life cycle" (Cummings & Sayama, 1995, p.9).

2.1.5: Length of therapy in other therapeutic models

CBT has a pronounced leaning towards short-term work. This characteristic was both pragmatic and one suited to the personal temperament of its founders, showing a

preference for 'doing the business.' The success of the early short-term CBT models, along with increasing socio-economic imperatives, have played a part in shifting the whole psychological therapy field towards working over shorter time periods.

The traditional model of psychodynamic therapy has been a long-term one. This is partly because the theory has stressed the need to 'work though' problems of long duration, usually developed in childhood (Jacobs, 2004). The fact that many of the underlying dynamics of these problems are held to be unconscious may make this working through a lengthier process, typically lasting years rather than weeks or months. Humanistic therapy has typically argued against this length of therapy and has seen giving ample time as part of the respect that should be extended to clients (Rogers, 1967). Person-centred approaches have also been resistant to the idea that therapy should be structured and focused by the therapist for fear of imposing the therapist's agenda on the client. This reticence to focus may have resulted in humanistic therapy developing more as a 'medium term' therapy than a brief one. Perhaps in response to the demand for shorter term therapy, however, briefer models for both psychodynamic (Della Selva, 2004) and humanistic (O'Connell, 2001) models have emerged in more recent times.

Paradoxically, as this shortening of other models has developed, longer-term versions of CBT have emerged: Schema-Focused Therapy (Young et al, 2003) and Dialetical Behaviour Therapy (Linehan, 1993) are both concerned with working with client personality problems.

There is growing consensus on the potential efficacy of short-term work and conversely a more sceptical attitude towards long-term work: although the definition of length itself is problematic. Additionally, most therapists, even those with a preference for shorter-term work, agree that some clients will require longer, sometimes considerably longer, periods of therapy. At the end of the day, the real differences between models may turn on how large this group is estimated to be (Cummings & Sayama, 1995).

In relation to this study, we might hypothesise that a trainee open to shorter-term work (Bolter et al, 1990) would be more open to the CBT model, although the polarisation that might have been expected in years past may not be so pronounced now.

The relatively short-term nature of CBT has affected other areas of practice. It has led to more emphasis on structure and direction (Principle 2). It may also have meant that CBT had to focus on more sharply defined problems in order to make best use of its more limited time perspective, compared to other approaches (Principle 3). CBT has followed the behavioural tradition in defining problems in concrete, often behavioural and/or symptoms based terms. The focus on problems is shown in the development of the concept of the 'problem list' (Fennell, 1989; Persons, 1989). The problem list is a menu of problems agreed with the client and reviewed on a regular basis. It is used as a guide on when therapy may be finished and thereby is an aid to maintaining a focus on short-term therapy.

2.2: Principle 2: CBT is structured and directional.

2.2.1: The rationale for structure and direction

The debate about structure is sometimes confused because the term 'structure' is used in two rather different but inter-related ways. Firstly, structure may refer to a series of behavioural steps that therapist and/or client can follow within a session or series of sessions. CBT has a definite session structure that should be quite closely followed, generally in every session (Beck, 1995). The structure consists of sequential steps beginning with conducting a 'mood check' on how the client is feeling, followed by setting an agenda for the session. Agenda items, including checking homework tasks, are then pursued as session targets. The session finishes by setting a new homework task and by taking client feedback on the session. Structure in this sense can also be extended to the characteristic shape of the therapeutic intervention over time; for example, that CBT usually begins by targeting symptom relief and proceeds later to preventative work on underlying vulnerabilities (Beck et al, 1979; Wells, 1997).

One rationale for structure of this kind is that clients are often in a confused and chaotic period of their life and are emotionally aroused during counselling. Therapy structure can offer helpful boundaries within which this confusion and arousal can be contained. Therapists may sometimes forget that therapy is an unfamiliar experience for many clients. When clients know the structure it may be easier for them to learn their role in the therapy. Alford & Beck (1997) also argue that structure enhances the collaborative transfer of learning from the therapy context to the real life context.

Structured sessions are directional in that they are structured to the end of goal attainment. Sheldon (1995) notes that structured approaches within social and therapeutic work are associated with greater effectiveness. Both structure and direction need, however, to be negotiated with the client. Two aspects of the structure are especially helpful in conducting such negotiation: agenda-setting (collaborative agreement of issues to be tackled in the therapy session) and taking feedback (evaluating the client's perception of the usefulness of the session). Clients may be resistant to structure or direction or both (Beutler et al, 1994). Whilst it is recommended that the cognitive components of this resistance are explored (Leahy, 2001), it is often also helpful to adjust structure and/or direction.

A second usage of the term 'structure' in therapy may refer to the 'deep structure' of the therapy (Ivey et al, 1997). This kind of structure lies in the therapist's ways of understanding the client's problems and assumptions about the underlying psychological change processes that the therapy is attempting to facilitate. Another collaborative value of CBT, however, is to try to make this structural rationale as explicit as possible to the client:

> Structure is necessary for collaboration. Patients must learn how improvement is obtained in order to view themselves as collaborative partners in the therapeutic enterprise. To teach patients in this manner, therapists must themselves possess a theoretical rationale for specific treatment techniques. Otherwise, there is no structure on which to base the process of collaboration... The American Board of Professional Psychology states explicitly that to earn the ABPP Diploma, a psychologist must treat or make recommendations 'in a meaningful and consistent manner... backed by a coherent rationale' (ABPP, 1996, p.3, cited in Alford & Beck, 1997, p.12).

'Direction' is perhaps another term that can be easily confused, in this case with Rogerian terms, 'directive' and 'non-directive'. It has been argued that CBT is directive and thus works against client self-determination. By using the terms 'offering direction' and 'being directional' one can clarify that 'accepting direction' and 'maintaining self-determination' are not mutually exclusive concepts (Hudson & Macdonald, 1985). It may also be helpful to consider the opposite of 'directional' which is 'directionless' (Bandura, 1969, quoted in Sheldon, 1995, p. 25).

2.2.2: Structure and Direction in Other Therapeutic Models

Psychodynamic therapists are not usually hostile to the notion of 'structure' in itself because they usually do have structural notions of the kind of interventions that they are trying to make (Eells, 1997). Whilst they can usually accept the idea that they are following a structure, perhaps more like a 'deep structure', they tend to be less happy with the overt structure of CBT, which they may see as taking spontaneity out of therapy sessions. This may inhibit the scope for 'free association' and thereby might both keep the subject matter at surface level (Persons et al, 1996) and prevent more 'unconscious' material from emerging (Milton, 2001). A fuller description of the psychodynamic reservations about CBT established by Persons et al (1996) is offered in Chapter 3.

Humanistic therapists, especially person-centred therapists and counsellors, are generally quite suspicious of the CBT adherence to structure and 'directiveness'. 'Person-centred' was the final term used by Rogers (1980) to describe a type of therapy that had previously been called 'non-directive' (Rogers, 1942) and 'client-centred' (Rogers, 1951). A key idea of the Rogerian approach is that therapists should not regard themselves as 'experts' in the client's problems and should therefore resist the impulse to give advice and make suggestions to 'direct' clients. At most, the therapist might facilitate the client in such markedly accepting ways that the chances of clients finding their own solutions is maximised. This is an influential notion in psychotherapy and is, to some extent, followed in CBT (Beck et al, 1979). Rogerians tend to hold a strong version of this principle and focus much therapeutic attention on avoiding direction of clients. Therapists who strongly follow the concept of 'non-directiveness' may therefore be wary

of anything that appears imposed on the client, and they may see the CBT principle that encourages the therapist to provide overt and directive structure in this light.

2.3: Principle 3: CBT is problem and goal-orientated

2.3.1: Rationale for a problem and goal–oriented approach

Hudson & Macdonald (1985) make the point that although all therapy models must have goals, the behavioural tradition holds that such goals should be *overt*. The problem-solving emphasis in CBT can clearly be seen in the therapy guidelines offered by Beck & Emery (1985, p. 172). They stress working on manageable problems as an important rationale for brevity:

> Because cognitive therapy is time-limited, many of the patient's problems will remain unsolved at the end of treatment. By the time treatment ends, the patient will have enough psychological tools to approach and solve problems on his own, knowing that the therapist is available for booster sessions if necessary.

The transfer of skills encourages the client to develop the potential to become her own therapist. Brewin (1996) explores the evidence regarding the effective elements of CBT treatment. He concludes that the transfer of problem-solving skills is likely to be one of the most effective elements. Evidence suggests that a main advantage of CBT for depression is that it promotes relapse prevention by increasing the client's ability to solve problems after therapy (Hollon et al, 1996). Jacobson et al (1999a: 1999b) also show that much of the efficacy of CBT with depression is likely to rest with relatively simple problem solving skills that can be taught by non-therapist staff.

Beck & Emery (1985, p. 171) invoke a deliberately business-like and problem-solving spirit by arguing that specifying a certain number of sessions "... puts in a task-orientated frame for *getting down to business.*"

2.3.2: Problem-solving in other therapeutic models

Although almost all therapies aim to solve problems, they may not have such a clear focus on 'problem-solving' as that presented in CBT. The focus on problem solving in CBT is closely related to its preference for a briefer time scale. As both psychodynamic

and humanistic therapy, especially in traditional form, do not have this short-term emphasis so they have characteristically different ways of solving problems, often focusing 'on underlying mechanisms' rather than overt problems. Various cognitive and behavioural approaches to problem solving have stressed concrete and specific steps in the process (D'Zurilla & Nezu, 1999). These concrete steps invariably focus more on managing overt problems better, rather than the more psychodynamic focus on modifying the 'underlying mechanisms' or the supposed origins of the problem. CBT therapists, as a first assumption, are more likely to come directly to the overt problem, whereas a psychodynamic therapist is more likely to look underneath it. Such problem solving is particularly helpful when it takes the client's current problem-solving style into account (Sheldon, 1995). Humanistic therapists such as Rogers have favoured exploring problems. Gestalt therapy has been distrustful of 'rational' approaches to problems. Its founder, Fritz Perls, suggested that the humans should 'lose their minds and come to their senses' (Clarkson & MacKewn, 1993). Some recent approaches to CBT have conceded that CBT practitioners may indeed have been over-rational in their approach to problem solving (Hayes et al, 2004). Hayes et al (2004) suggest it is important to consider what strategies the client has used previously to solve the problem. Sometimes the client may be trying to use the therapy to buttress a dysfunctional solution. Hayes et al (2004) therefore suggest that it is important to invest more effort in ensuring that the client has 'accepted' the problem and is 'committed' to changing it. Problem-solving that preceded such acceptance could prove premature and ultimately unsatisfactory. This line of reasoning, however, is not advocating abandoning rational problem solving per se but is suggesting that change processes may have non-rational elements.

2.4: Principle 4: CBT uses an educational model

2.4.1: Rationale for an educational approach to therapy

> It is helpful for the therapist to view himself as a teacher of anxiety-management skills. (Beck & Emery, 1985,p.185)

Learning has taken a central role in the behavioural and cognitive approaches of both general psychology and psychotherapy. CBT practitioners often use the term 'psycho-education' (Hawton et al, 1989) to describe this aspect of their practice. This term seems

to be used in two slightly different ways. In the first use of the term, the therapist seeks to help the client to 'learn to learn' (Beck, 1976, p.229): that is, how to open one's thinking and behaviour to other possibilities. This is important in therapeutic work because clients may be stuck in the so-called 'neurotic paradox' (Raimy, 1975) and by failing to learn from negative experiences, may keep repeating the same mistakes.

The second sense in which 'psycho-education' is used is that of offering the client new information from a psychologically informed point of view. It seems likely that more clients are now accessing information about their psychological problem areas and possible treatments from the Internet (Taylor & Luce, 2003). The quality of Internet information is highly variable so that clients may still not be well informed about the nature of depression, for example, and may regard some of the symptoms as being more pathological than they actually are. Furthermore, if they are depressed, their thinking about their own condition is likely to be influenced by the pessimism and negative attention bias that are characteristic of depressive thinking (Beck, 1967: Brewin, 1988: Gotlib & Hammen, 1992).

Even when appropriate psycho-educational information is available, it cannot be assumed that clients will assimilate it. There is much evidence that patients in general medical settings do not assimilate key health information (Williams et al, 2000) and this may be even more pronounced in the field of psychological therapy. It is because of this problem concerning the assimilation of more functional information that psycho-education is tackled in a systematic way by CBT practitioners.

2.4.2: Psycho-education in other therapeutic models.

Some humanistic practitioners have expressed reservations about 'psycho-education' – probably because of the assumption of 'expert knowledge' that lies at its heart. Barker & Buchanan-Barker (2004) warn that psycho-education can be a kind of 'one size fits all' and seemingly kind treatment strategy that is actually more interested in fitting the 'patient' into the treatment programme than in responding to the patient as a unique individual.

Debates about 'patient empowerment' in health services often focus on the nature of treatment programmes and individuals' respond to them. Cahill (1999) reviewed the literature on patient participation and suggested criteria to assess genuine participation:

1) There should be a relationship between the treatment agent and the patient.
2) The knowledge gap between the two should be narrowed.
3) The treatment agent's power should be surrendered to a degree.
4) The process should result in selective activities.
5) The patient should make a positive gain from the process.

Treatment protocols have played an important role in the development of CBT (Clark, 1996). Most protocols contain a psycho-educational phase. The five criteria above are generally well covered in the CBT literature – for example, the emphasis on collaboration and therapeutic relationship within the principles of CBT being now considered.

The issue of power is obviously complex. CBT has been criticised for not addressing the issue of their social power and of not adopting a 'power sensitive' perspective (Spong & Hollanders, 2003). Critics, however, do not always follow Weber's useful distinction between power and authority – Weber defines authority as legitimate power (Gerth & Mills, 1991). The patient or client gives the therapist at least some legitimacy by voluntarily entering into a relationship with them. Beyond that point, abuse of legitimacy or power is somewhat protected by professional codes of ethics. If CBT therapists follow the suggested structure and protocols, they may minimise potential abuse by explaining the rationale for interventions, seeking feedback from clients and trying to keep therapy as parsimonious as possible.

Humanistic reservations about therapist 'expertise' may not have considered distinguishing between 'being an expert' and 'having expertise'. A client may frequently expect that the therapist will lay claim to some expertise. The therapist can, however, regard her expertise as expertise about people in general but believe that this will be of little avail unless it can ally itself with the client's expertise about her life. This view is consonant with the concept of 'collaborative empiricism' described by Beck et al (1979).

Humanistic therapy has been especially influenced by the 'anti-psychiatry' movement of the 1960s and 1970s and this position has revived again recently within humanistic therapy (Newnes et al, 2001). Newnes et al (2001) advocate an 'anti-psychiatry' position within the person-centred/humanistic model and argue for the need to conduct an on-going fight against the medical model of mental health in a way reminiscent of the 1960s anti-psychiatry movement.

There is an interesting historical twist here in that there is a case to be made for the early British behavioural therapists as more effective opponents of the 'medical model' in psychiatry than the 'anti-psychiatry' movement. The behavioural therapists set up effective alternative treatments based on idiographic formulation of the patients in opposition to 'symptom based treatment' (Bruch & Bond, 1998). Paradoxically, CBT practitioners in more recent times have been more content to work within symptom based protocols, though they would also favour combining such work with an idiographic formulation of the client (Beck, 1995)[4]. As some of the 'expertise' claimed by CBT therapists would involve, for example, the pragmatic use of DSM terminology, person-centred therapists with an 'anti-psychiatry' perspective might well find this aspect of CBT hard to accept. Many CBT therapists are located within mental health settings (BABCP, 2005: personal communication) and may therefore seem to some humanistic practitioners as being 'guilty by association' with psychiatry.

From a psychodynamic point of view, there could be educational intent in trying to facilitate the client's 'insight' into his condition. Psychodynamic therapists, however, may tend to see the generation of insight as part of a more general aim to make the 'unconscious conscious' (Jacobs, 2004) and this could just be seen as part of psycho-education as defined in the first definition of 2.4.1 above. Freud's concept of the 'compulsion to repeat' (Jacobs, 2004) is quite close to Raimy's (1975) concept of 'neurotic paradox.' Psychodynamic therapists are, however, less focused on 'maladaptive behaviours' than on individual experiences and so might well avoid the more explicit and

[4] There is further discussion of this point under consideration of principle 10.

'information giving' activities of psycho-education in CBT that are inevitably focused on more general experiences.

2.5: Principle 5: Homework is a central feature of CBT

2.5.1: Definition of 'homework' in CBT

The educational emphasis of CBT is also evident in the advocacy of 'homework'. This term refers to the tasks that clients are asked to undertake between therapy sessions. Homework assignments can operate over different areas of behaviour and cognition, either or both of which may be stressed in different phases of therapy. Early assignments can include reading specific information about, for example, depression or a specific anxiety problem. Clients are asked what they thought and felt about the experience of such reading at the start of the next session and whether any further questions arise in their minds. This type of activity, known as bibliotherapy, appears acceptable to clients and may sometimes constitute an effective intervention in its own right. Health authorities are increasingly supplying 'book prescription' schemes (Frude, 2005). Later on, homework may become more experiential – for example, a client who has difficulties relating to others because of social anxiety may be asked to open a low-risk conversation and, at the same time, be aware of his negative thoughts and feelings - a 'behavioural experiment' (Wells, 1997; Bennett-Levy et al, 2004).

Innovative aspects of homework are becoming evident in CBT and other approaches, including the use of video recording (Wells, 1997), email (Murdoch & Connor-Greene, 2000) and the internet (Taylor & Luce, 2003). There have been clinical trials using CD-rom based CBT materials currently running in the NHS (NICE, 2005). These developments are often part of a 'stepped care' approach (Williams, 2002).

'Stepped care' attempts to stimulate wider dissemination of CBT by interventions that vary the amount of therapy materials (books and other resources) and therapist time on a sliding scale. First step interventions may involve all materials and no therapist time. Later steps include more therapist time if the client has not responded to earlier steps. Such developments are likely to strengthen the role of homework and 'out of session' work.

2.5.2: Rationale for the homework principle in CBT

CBT theory assumes that psychological change is generally hard to achieve and is unlikely to come about from the generation of insights alone (Beck et al, 1979; Beck, 1988; Bennett-Levy et al, 2004). Homework tasks described above focus on different levels of change as defined within CBT. Listening to a session tape is a deliberately low-key activity and aims to ensure that this, usually early, task is one that the client can do, thus reinforcing therapy as a 'self-efficacious' experience. Tasks such as keeping thought records reinforce skills learnt in sessions as well as being valuable interventions in themselves. Behavioural experiments are seen as particularly powerful homework tasks, aiming to act as experiential disconfirmation of beliefs. (See later Section 2.7.2 on inductive methods).

More generally, these represent a strategic factor: that CBT has taken an intentionally systematic approach to ensure that gains in therapy transfer to the client's everyday life (Ivey et al, 1997; Roth & Fonagy, 1996). Hollon et al (1996) have hypothesised that this dimension of CBT explains why it shows greater gains in current methods for measuring efficacy and effectiveness than do some other approaches: by helping to minimise relapse at follow-up.

2.5.3: Homework in CBT: Compliance and Resistance

Burns & Spangler (2000), Burns & Nolen-Hoeksema (1991) and Persons et al (1988) have researched the effectiveness of setting homework in naturalistic therapy settings. These studies showed that clients completing homework assignments are more likely to make and maintain gains in therapy. There may, however, be other mediating variables that affect outcomes – for example, the type of clients who are prepared to do homework tasks might in any case be more likely to make gains regardless of any therapeutic activity that they had undertaken (Kazantzis, 2000; Kazantzis & Ronan, 2006; Kazantzis & Deane, 1999; Kazantzis et al, 2000; Kazantzis et al, 2005a; Kazantzis et al, 2005b; Kazantzis & L'Abate, 2007).

Research on the use of homework tasks in psychotherapy have been focused on finding:

1). Factors influencing compliance with and resistance to the completion of homework and,

2). The degree to which homework completion influenced therapy outcomes.

Several writers have noted that levels of resistance to homework tasks can be quite high and practitioners often report difficulties with setting homework (March, 1997). The standard advice for therapists in this regard has been to set the homework tasks as 'no lose ' experiments and to start them in session before setting them as homework:

> It is helpful when setting up assignments initially to stress that useful data can be obtained even if the patient does fail to do her homework. In this way, the patient who does not do the homework is less likely to brand herself a failure and thus feel more dysphoric (Beck, J, 1995, p.255).

Beck et al (1979) suggest that client and therapist might agree that the therapist telephone the client to see if tasks had been fulfilled. Dryden (1985) describes the factors that inhibit and enhance the client's motivation to do homework. In a case study of a phobic client, the resistance appeared to be related to the fact that the homework tasks invariably involved facing up to previously avoided situations. Dryden recommends negotiating with the client to achieve "challenging but not overwhelming" tasks. Hansen et al (1992) also emphasise the importance of negotiation in their study of OCD (Obsessive Compulsive Disorder) clients, for whom negative experiences of homework often led to dropout. Clients who dropped out of therapy were both less likely to complete homework and also experienced less anxiety when doing their homework than clients who completed the treatment. This not only points to the efficacy of doing homework but also highlights the fact that the homework itself must be meaningful and at times, challenging, to the client. Leahy (2001) argues that non-compliance with homework can be often related to clients' 'self-limiting strategies', designed to avoid further loss, humiliation or regret. Leahy (2001) suggests that therapists can help by identifying such strategies, examining the negative implications of achieving goals and by encouraging clients to accept their own limitations.

2.5.4: Homework and outcome in therapy

Compliance is frequently assumed to correlate with good therapeutic outcomes. A number of studies have supported this notion. Persons et al (1988) studied 70 clients treated for depression in their private practice. They judged improvement by reductions in scores on the Beck Depression Inventory (BDI) and found that clients who had regularly completed homework assignments reduced their BDI scores by 65.5%, three times greater than that observed for clients who had not regularly completed homework tasks. Burns & Nolen-Hoeksema (1991) completed a retrospective survey of 185 clients who had had CBT treatment for depression. They were particularly interested in whether the clients' perceptions of therapist empathy were predictive of good outcome. Experience of therapist empathy was indeed found to be predictive of outcome. They also found, however, that homework completion had a positive effect on outcome over and above that of the client's perception of therapist empathy.

The studies so far reported are limited by the lack of random allocation to the homework and no-homework conditions, leaving them open to the criticism that the correlation could be related to some other intervening variable such as social class or attitude to treatment. Neimeyer & Feixas (1990) studied cognitive treatment of 63 clients with unipolar depression, randomly assigning half the clients to a cognitive treatment condition that included regular homework and half to a cognitive treatment condition not including homework. Homework completion was found to be predictive of greater treatment gain by the end of therapy, but interestingly, not at 6 months follow-up. The study also included assessment of the degree to which CB skills had actually been acquired and this was predictive of the maintenance of gain at 6 months. It appears then that homework completion in itself was not a guarantee of cognitive behavioural skill acquisition. Clients not included in the homework condition showed signs of CB skill acquisition and when they did, they showed the same ability to maintain gain as those who had been in the homework condition.

Burns & Spangler (2000) also used random assignment to a homework condition in a study of cognitive therapy for depression. Their data was consistent with the hypothesis that homework compliance has a causal effect on changes in depression. Clients who did the most homework improved more than those who did little or no homework. In contrast, severity of depression did not appear to influence homework compliance. Furthermore, homework compliance did not appear to be a proxy for any other variable, such as motivation.

Kazantzis et al (2000) conducted a meta-analysis of studies researching the effect of homework in psychotherapy. Although, there are an increasing number of studies with quite large sample sizes showing positive results, many of the studies generated only small power levels so that effect sizes themselves were very variable.

2.5.5: Homework in other therapeutic models

Kazantzis et al (2005a) show that CBT therapists report a significantly greater use of homework tasks than practitioners of other modalities. CBT therapists do not, however, 'own' homework as a therapeutic idea and other approaches are beginning to use homework tasks, some in a major way (Rosenthal, 2001; Kazantzis et al, 2005a). Kazantzis et al (2005a) surveyed all clinical psychologists in New Zealand and found that a majority, regardless of orientations, defined themselves as regularly giving homework tasks to clients and saw homework as an important part of their practice. CBT therapists were somewhat more likely to give homework but the differences of usage rates amongst different orientations were not great.

Person-centred counsellors have sometimes reported a sense of inhibition about asking clients to do homework and this may relate to a 'person-centred' desire to avoid the role of 'expert' or 'teacher' and appear patronising (Mooney & Padesky, 1998; Persons, 1989). There could also be a language effect here because in UK English, the 'term' homework is especially related to a school setting and not really, for example, to a university setting. Informal enquiries have established that in American English, in German and in Japanese, the term would be used equally in schools and universities.

Traditional approaches to humanistic and psychodynamic therapies, however, put more emphasis on the role of insight in generating psychological change and do not have the same imperative for the client to actively experiment with her behaviour as in CBT. Some other therapists may regard CBT as 'pushy' or 'bossy and impatient of inaction'. Interestingly, Kazantzis et al (2005b) report a similar attitude to homework amongst trainees on a CBT Diploma course in New Zealand.

Reluctance to use homework may be related to the strong emphasis that other therapies place on the therapeutic relationship and the therapeutic encounter. The humanistic therapies advocate the development of an 'I-Thou' (Buber, 1970) relationship between therapist and client, the honesty and integrity of which is held to be associated with positive emotional growth for both. The therapeutic encounter is held to be the key element so that the time when homework could be completed - between therapeutic encounters – may be of less interest.

Stricker (2006, p.221) reviews the use of homework in psychodynamic therapy and notes that:

> The approaches to treatment that focus on the activity within the session, rather than outside, would appear to be least compatible with the use of homework. Foremost among these approaches are psychodynamic psychotherapy ...and many of the humanistic and experiential therapies. Psychodynamic psychotherapy traditionally places emphasis on the introspective activities of the patient and the therapist. To assign homework would seem to deviate from the framework because it places the therapist in the role of an active, directive authority, and it directs patients' attention away from the therapeutic interaction and their own internal processes toward the area outside the treatment room... However, appearances sometimes are deceiving. The use of homework, even in traditional psychodynamic psychotherapy, is more widespread than is readily seen. For example, there are few practitioners of psychodynamic psychotherapy who do not ask their patients to remember their dreams, perhaps even to write them down... This is a type of journaling that would be recognizable to any practitioner of cognitive behaviour therapy, although that is hardly the specific assignment that would be given.

Thus, he argues, although the use of homework would be incompatible with "... the strict application of ... psychoanalysis" (p.236), it is possible to devise a set of criteria for its use in more recent psychodynamic models: describing his own use of "... an assimilative,

integrative model of psychodynamic therapy" (p. 219). These criteria stress the fact that homework in this modality should be highly individualised and non-prescriptive.

There is also evidence that homework is being increasingly used in most other therapies, especially brief therapy (Halligan, 1995) and in the systemic therapies concerned with working with groups, couples and families (Schultheis et al, 1999; Jongsma et al, 2000a, 2000b).

Although homework has not featured strongly in the theoretical literature of either humanistic or psychodynamic therapy, it has begun to appear in accounts of practice of those therapies, especially in their 'brief' format versions. Accounts of the use of homework in humanistic therapy include logotherapy (Henrion, 2001), client-centred therapy (Corey, 2001), expressive focusing therapy (Engel et al, 1991) and counselling generally (Hay & Kinnier, 1998). Markowitz (1995) and Pollack (1999) have supplied accounts of the use of homework in brief dynamic therapy.

To summarise, setting homework has played a key role in the development of CBT, especially in attempts to maximise the chances that gains made in therapy are generalised to both life outside sessions and life after therapy finishes. There is evidence suggesting that homework does enhance therapy outcomes: though there may be other mediating variables. Homework tasks have been used in other active modes of therapy but have perhaps been inhibited in some schools of therapy by a very strong emphasis on the interpersonal and experiential encounter in the therapy session itself. Even in those modes of therapy, however, there is also evidence of an increasing willingness to consider homework tasks as additional options in therapy. Kazantzis & Ronan (2006) have suggested that the use of homework is a candidate for consideration as a 'common factor' in modern psychotherapy.

2.6: Principle 6: CBT uses the Socratic Method.

2.6.1: The rationale for the use of Socratic methods in CBT

For a shift in cognitive perspective to take place, a client's thinking usually needs to include a perspective that includes reflective and critical thinking. This type of thinking is appropriately defined using the name of Socrates and linked with the Socratic method. As Popper (1959) remarks, Socrates is known for, "... his belief that the search for truth through critical discussion was a way of life – the best he knew." (p.157). The main use of Socratic method in CBT is by 'guided discovery', mostly by Socratic questioning:

> The cognitive therapist strives to use *the question* as a lead as often as possible... Good questions induce the patient to: 1) become aware of what his thoughts are, 2) examine them for cognitive distortions, 3) substitute more balanced thoughts, and 4) make plans to develop new thought patterns (Beck & Emery, 1985, p.177).

Padesky (1993, p.1) suggests that CB therapists use the method of 'guiding discovery rather than changing minds' and offers guidelines to shape patterns of questions interspersed with summaries to achieve effective Socratic questioning. Nonetheless, this key skill of CBT remains one of the hardest to master. The technique can be experienced as subtle persuasion and this may be off-putting to those it is aimed at (Padesky & Greenberger, 1995). Heesacker & Meija-Millan (1996) present evidence from psychological and psychotherapeutic research studies showing that therapist influence may be optimal when clients perceive a small gap in expertise between themselves and their therapists. Thus an over-persuasive therapist may produce a counter-reaction in the client. Some trainees may similarly have negative counter-reactions to over-persuasive trainers. Fennell (Personal communication) has suggested that the ideal trainer style for teaching cognitive therapy comes from adult education theory - influenced by andragogy (trainee-centred learning, Knowles, 1984), encouraging experiential learning and facilitating questioning and problem-based learning rather than lecture-based learning.

2.6.2: Socratic Methods in other therapeutic models

Even the seemingly simple injunction to ask questions can be problematic for a CBT trainee who has had previous training in person-centred counselling. This problem could arise because trainees may come to initial counselling training with a tendency to ask too many questions with the result that the attention that they put on asking questions distracts them from listening well (Inskipp, 1996). Whilst the aims of initial training in

counselling are dominated by efforts to get trainees to balance their questions with more use of paraphrasing and reflection, the training process may result in an over-emphasis on 'reflective listening'. Hence CBT trainers may consider that counsellors in training for CBT reflect too much on the content of what the client says and not enough on its underlying cognitive content. Trainees learning CBT from a person-centred perspective may feel that they are abandoning a hard won skill in listening when they are encouraged to ask questions in the way demanded by Socratic methods.

Another perception of CBT that may trouble both humanistic and psychodynamic therapists is that it has what can be seen as an over-persuasive 'technology' that may overwhelm the client. All therapeutic models perhaps have 'characteristic sins' and the sin of CBT may be over-persuasion. Humility is not a failsafe defence against this sin. Even Socrates was seen by some as indulging in 'mock modesty' (Nehemas, 1998) during which he would ask apparently guileless questions that increasingly tied his dialogue partner into knots – in CBT terms, he thoroughly 'decentered' his interlocutors – causing them to 'experience one's own role in constructing reality' (Safran & Segal, 1990, p.6). Socrates was not always thanked for his pains. As Socrates left no written work, we are dependent on the possibly idealised picture of him from Plato. It is perhaps fortunate that few of us would be able to match the skills of dialogue portrayed in these accounts. We may however safely concur with Padesky (1993) that over-persuasion is simply ineffective, at least in the longer term. Although neither the humanistic nor psychodynamic models of therapy explicitly espouse a 'Socratic' approach to questioning, they both give some kind of role to asking questions and these may at times take on a Socratic form. Both approaches foster more wariness of persuasion than CBT, and so would be less likely to systemise question asking as recommended in CBT (Leahy, 2003: Padesky & Greenberger, 1995; Wells, 1997).

2.7: Principle 7: The therapy and techniques of CBT rely on the inductive method

2.7.1: The rationale for cognitive and behavioural inductive methods

The Shorter Oxford English Dictionary (SOED, 3rd Ed, 1969) offers eight different definitions of 'induction'. The meaning coming closest to meaning indicated in the principles of Beck and Emery (1985) would be:

> The process of inferring a general law or principle from the observation of particular instances (SOED, 1969, p.257).

In light of the above discussion of the Socratic method it is interesting that the first definition offered in the dictionary is "The act of inducing by persuasion." Beck and Emery (1985) intend that some of the values of inductive scientific method may be used to help clients regard their dysfunctional thoughts and beliefs "hypotheses rather than facts" (p.188). Beck and Emery (1985) argue that inductive activities help to achieve decentering because these activities can counteract the influence of negative attention bias and other dysfunctional cognitive processes in psychological problems (Brewin, 1988). The concept of negative attention bias describes shows how the focus of attention in depressed clients, for example, is frequently distorted by the depression and pays disproportionate attention to negative information and takes less notice of positive information. To bring clients to more balanced ways of thinking – and thereby promote positive mood and behaviour - the therapist tries to help them to decenter from their negative mode of thinking. The decentering process then progresses to allow the client to reflect on their thinking and modify it. Thus the decentering process is usually inductive as it follows from many particular instances of clients' experiences, during which they may have, for example, thought of themselves as 'having failed' but moved to a more general self categorisation as 'being a failure'. The desired therapeutic end of this process is, however, 'disconfirmation' of that over-generalised thinking (Safran & Segal, 1990).

CBT has been seen as a therapeutic approach that has many methods and techniques. These methods are often divided into two main groups: cognitive techniques and behavioural techniques. What unites the use of these techniques is they will be employed according to the therapist's overall formulations of clients and their situations, as will be discussed later.

CBT is preceded by a psychological and social assessment. This assessment culminates in the development of a formulation of the client's main problems (Persons, 1989; Beck, 1995). Techniques are selected for their ability to impact on this formulation in the way calculated as most likely to produce change. Cognitions hold an important, though not exclusive role, in cognitive behavioural formulations. For example, a formulation of an anxious client might reveal that fearful cognitions are linked to equally strong behavioural avoidance. The client's thoughts might show a preoccupation with just how intolerably bad and dangerous these anxious feelings are. Knowledge of the actual processes of anxiety, however, would indicate that these physical sensations are not usually as dangerous as they seem during the client's anxiety episode. Furthermore, exposure and habituation usually dispel these anxious symptoms. A cognitive behavioural intervention might encourage the client to change an avoidant behavioural response so that the client will 'stay with' the anxious feelings; hoping to disconfirm the distorted and exaggerated appraisal of the degree of danger that they represent (Foa & Kozak, 1986).

In depression, a formulation might reveal that the client has become behaviourally withdrawn and spends much time at home ruminating on what a 'failure' she is. A cognitive behavioural therapist would be likely to hypothesise that her thoughts and behaviours are linked but might take a pragmatic approach about which factor was the primary influence. The therapist might choose to intervene by conducting a behavioural experiment on whether if the client increases activity levels, this might lead to spending less time in depressive rumination. Alternatively, the therapist might try to get the client to modify her negative thoughts to see if this would increase the likelihood that she will go out. Intervention options would be selected by specific knowledge about how interventions work with different symptom patterns, followed by collaborative discussion with the client. For example, practitioners generally consider that the more severe the depression, the stronger the indication to tackle behavioural problems first (Beck et al, 1979; Fennell, 1989). On the other hand, if the client is simply not willing to try such a strategy, it is likely to be unhelpful to push the client too hard.

We can see in these examples that a variety of techniques might be relevant in CBT interventions. The case formulation is used, along with client choices and preferences, to

plan a series of interventions. CBT has been regarded as relatively technically eclectic[5] in its approach to borrowing techniques from other therapies to target key problems in its formulations (Dryden, 1992). CB therapists argue, however, that the theoretical integrity of the model is maintained by the concept that, although it is technically eclectic, techniques selected should also aim to impact on key cognitive elements in client formulations. CBT is a formulation-driven therapy, not a techniques-driven therapy (Wells, 1997).

2.7.2: Cognitive technique

A detailed description of cognitive techniques is beyond the scope of this review but can be found in Leahy (2003). A particular focus for this chapter will therefore be on the use of the 'thought record' (Leahy, 2003: Greenberger & Padesky, 1995), which can be regarded as "... the primary tool for patients to evaluate and respond to their automatic thoughts "(Beck, J. p.125).

Firstly, a brief overview of the basic rationale of how cognitive techniques are used will be presented. Secondly, some guidelines are offered for working with different levels of cognitions.

It is not the therapist's job to persuade the client from holding negative automatic thoughts and beliefs. Attempts at persuasion are not only usually ineffective but may also be counter-productive - for example, sometimes by prompting clients to 'defend' their beliefs more fiercely (Bennett-Levy et al, 2004; Leahy, 2003; Safran & Segal, 1990). The therapist's task is rather to facilitate clients in examining and questioning their beliefs.

CBT distinguishes three main levels of cognitions - automatic thoughts, assumptions and core beliefs (Beck & Emery, 1985). Automatic thoughts are not immediately conscious but are relatively accessible to reflection. They represent ways of appraising immediate moment-to-moment events. In the middle of a teaching presentation, a teacher, for example, might observe a student looking bored and might think to himself '*I am making*

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[5] A technically eclectic approach stresses the importance of a theoretical formulation of the problem based on a coherent rationale but is prepared to draw from a range of diverse practical approaches to seek change in the problem.

a mess of this'. This appraisal might be very specific to this particular situation. The teacher might consider himself to be generally competent in his teaching and his life. On the other hand, this thought might represent a deeper cognitive set that contains appraisals such as '*I am really a boring person'* (unconditional core belief) and/or '*Unless my teaching goes well, I'm a failure'* (conditional assumption).

It is generally suggested that cognitive behavioural therapists should begin cognitive interventions at the level of working with negative automatic thoughts (Blackburn & Davidson, 1994; Beck, 1995; Leahy, 2003; Grant et al, 2004). Many techniques, such as using a thought record, are used to help the client review and challenge their automatic thoughts. The techniques are all designed to maximise the chances that therapy will proceed in the Socratic fashion described earlier. In many cases, it may not be necessary to take cognitive restructuring far beyond the level of negative automatic thoughts. This work can itself, and in conjunction with behavioural work, result in major symptom relief. Beck (1995), however, suggests that some work at the dysfunctional assumption and maladaptive belief level is useful as part of a relapse prevention stage of the therapy.

The fact that clients write down negative thoughts is an important part of the rationale for the thought record. Beck (1976) makes the point that cognitive techniques often represent a 'common sense' (p.6) strategy to undermining negative thinking. Good mental functioning may be dependent on the mind being able to monitor and review the accuracy and adaptability of its appraisals (Epstein, 1998). Conscious effort rarely needs to be used during these mental housekeeping activities. If a client becomes depressed, however, these normal everyday cognitive activities do not work as well as they normally do. The depressed client's thinking is subject to negative distortions, attention biases and mental fatigue, resulting in less adaptive functioning – often evident in a 'vicious cycle' of negative thoughts and feelings (Fennell, 1989). The client is helped to take the mental steps to review their thinking in the way they would when they were not depressed. It is difficult for the depressed client to follow the cognitive steps involved in mental review and problem solving (Gotlib & Hammen, 1990).

2.7.3: Behavioural techniques:

CB therapists use techniques from behaviour therapy. The main techniques are exposure therapy, graded task assignments, activity scheduling, self monitoring, behavioural experiments and behavioural diaries (Hersen, Ed., 1995). Other behavioural methods such as contingency management are described in Sheldon (1995). The only real point of departure between cognitive and behaviour therapy has been the concept that these techniques are effective both in their own right and as reinforcement of cognitive change: in that they disconfirm dysfunctional client cognitions during 'behavioural experiments' (Bennett-Levy et al, 2004). For example, the client with panic disorder believes that the panic symptoms will drive her mad. Exposing herself to situations that have triggered panic reactions in the past and refraining from 'safety behaviours' might mean that she can find that she does not go mad. Repeated experiences like this may eventually disconfirm the belief. The likelihood of such 'disconfirmation' has resulted in debate between cognitive therapists and behaviour therapists (Rachman, 1997a). Cognitive therapists have argued that adding cognitive elements to, for example, exposure treatments enhanced their effectiveness whereas behaviour therapists argued that they made no difference. Each party was able to offer some supportive evidence for its case (Rachman, 1997a; Eysenck, 1997).

The conceptual framework offered by Brewin (1996) has been helpful in resolving this debate, suggesting that one must distinguish firstly, between 'situationally accessible' and 'verbally accessible' knowledge, and, secondly, between specified and generalised disorders, to understand the relative contributions of cognitions and behaviours in different disorders. Verbally accessible knowledge or insight allows reflective techniques to be effective. Situational knowledge may, however, require a specific type of stimulus to provoke emotionally relevant knowledge. This is often the case in anxiety disorders, where discussion of fear experiences without some feeling of anxiety being actually present does not seem helpful (Foa & Kozak, 1986). Brewin also uses the distinction between specific cognitions linked to specific disorders: for example, the highly specific thinking that goes with panic (Clark,1996) - and the more generalised cognitions that go with generalised anxiety disorder (Wells, 1997) to suggest ground rules for choosing the interventions most likely to shift particular types of thinking: sometimes these may be

cognitive interventions that shift behaviours and sometimes they will be behavioural interventions that shift cognitions.

2.7.4: The use of inductive techniques in other therapies

Other therapies have argued not so much against inductive techniques per se but that CBT has been over-concerned with technique (Weishaar, 1993). Wilkins (2002) argues from a humanistic perspective that over-concentration on techniques undermines the therapeutic relationship because the therapist may be thinking about technique and thereby fail to be 'genuine' with the client. Technique is therefore viewed as having potential for artifice - so other therapists may become averse to using much conscious technique. Rogers (1980) expressed great alarm about the fact that certain counsellors advocated that empathy is achievable through the skill of reflection. Consequently there has been little development of the idea of a portfolio of skills in this model - a distinct contrast to CBT. Tolan (2003) distinguishes between skills and techniques in person-centred therapy. Skills are all connected with making and deepening therapeutic relationships. Techniques, in the sense that they might be understood in CBT are not described. There have, however, been advocates of revised humanistic models that have emphasised skills learning (Carkhuff, 1987; Egan, 2002) though their work is now rarely acknowledged by humanistic therapists.

The methods of psychodynamic therapists have also been very much focused on the development and maintenance of the therapeutic relationship. They too have been suspicious of the array of techniques of CBT (Milton, 2001). One reason for this may be the psychodynamic aim to address 'underlying' issues and corresponding suspicion of symptom relief (Persons et al, 1996).

This brief review has shown that other therapy schools are likely to hold reservations not only about the many specific techniques used in CBT but indeed about the notion of technique itself. These beliefs obstruct interest in CBT and especially to learning CBT techniques. The 1995 versions of CBT principles (Beck, J., 1995) are broader than the 1985 (Beck & Emery, 1985) version. The 1995 version drops the word 'inductive.' This may represent a more populist intent of the author, though it is also probably true that

there is less emphasis on scientific 'veridicality' (i.e., the view that accuracy of perception is very closely tied to 'positive' functioning) in more recent CBT texts (Safran & Segal, 1990; Padesky, 1994). This view is now prevalent in the CBT literature and would mean that cognitions might be explored more in terms of functionality rather than in terms of their accuracy (Leahy, 2003; Brewin, 1996; Teasdale, 1996).

2.8: Principle 8: Cognitive therapy requires a sound therapeutic relationship:

The concept of the 'therapeutic relationship' holds a special place in psychotherapeutic discourse. On the one hand, the therapeutic relationship is held to be the chief 'common factor' to all models and to be a decisive, if not the decisive determinant, of therapeutic effectiveness (Orlinsky et al, 1994). On the other hand, it is also a term that can be vague in usage and its importance may be conceptually susceptible to becoming over-inflated (Feltham, Ed., 1999).

2.8.1: The rationale for the therapeutic relationship in CBT

Beck et al's (1979) description of the therapeutic relationship actually has much in common with that given in the work of Carl Rogers (1957; 1980), though unlike Rogers, Beck et al (1979) regard the 'core conditions' of empathy, warmth and genuineness, as necessary but not sufficient for change. A collaborative relationship in which the therapist has considerable skill and expertise is regarded as a further necessary factor. From a CBT perspective, one would expect individual clients to react differently to the same type of therapeutic relationship because they hold different beliefs about relationships. Some clients, for example, may expect the therapist to express a lot of empathy but others might suspect the sincerity of that same degree of expressed empathy.

In CBT, client and therapist should ideally form a 'team' that unites and works together against the client's key problems (Beck el al, 1979). To this 'team', the therapist brings a considerable amount of expertise and knowledge about psychological problems and processes of psychological change. This expertise may not, however, prove useful if it cannot be applied to this particular client's life. Clients therefore also bring expertise about their own experiences to the therapeutic 'team'. Neither client nor therapist can

usually succeed alone - success is most likely to come from uniting these two domains of expertise into a working partnership.

2.8.2: The Therapeutic relationship in other therapeutic models

From a humanistic perspective, for example, Rogers (1957) argues that the 'core conditions' are both necessary and sufficient for 'therapeutic personality change.' CBT, as described by Beck et al (1979) regards the core conditions as necessary, or at least very helpful, but not as sufficient to promote psychological change. CBT proposes that these conditions create a relationship within which the therapeutic work takes place. CBT theorists have also pointed out that such relationships are intrinsically rewarding (Sheldon, 1995) and do influence clients (Hudson & Macdonald 1986). There is also evidence that CBT therapists can combine the skills of giving direction, being empathic and influencing clients as, if not more, effectively than other types of therapists (Sloane et al, 1975; Keijsters et al, 2000). For CBT work to be effective, however, the therapist needs to have both conceptual and technical expertise as well as interpersonal skills (Padesky & Greenberger, 1995).

Like humanistic therapy, psychodynamic therapy has placed a heavy emphasis on the therapeutic relationship as the vehicle of change - though for rather different reasons. Psychodynamic therapists regard many client problems as being caused or exacerbated by unconscious wishes and motives. They believe that these unconscious wishes will themselves permeate the therapeutic encounter as 'transference reactions'. Transference reactions are, in brief, client responses based on unconscious wishes and may date back to primary relationships in early experience. As these experiences may have been encoded without language, they may be difficult to access via consciousness but may be evident in the client's transference reactions. Transference reactions may then elicit 'counter-transference' from the therapist. 'Counter-transference' reactions are regarded as the response that the client's transference elicits from the therapist's unconscious. Thus the therapeutic relationship becomes an arena in which these transference and counter-transference issues can be 'worked through' and resolved. 'Working through' has been identified as the main activity of psychodynamic therapy (Holmes, 2000). As noted in

earlier discussion, the activity of 'working through' has traditionally been seen as being a long-term process and this factor has therefore identified psychodynamic therapy as being in general a longer-term process than are other types of therapy.

CBT has tended to eschew such activities, certainly as a main focus of therapy. Beck et al (1979), for example, acknowledge that transference reactions do occur but suggest that they can be dealt with in the same way as any other type of cognitive distortion. In recent years, however, it has been acknowledged that such reactions can be more pervasive in clients with enduring personality problems (Beck et al, 2003; Layden et al, 1993; Young et al, 2003). In these cases, some of the activities of psychodynamic therapy, such as transference interpretations and 'limited re-parenting' may become part of CBT, especially in its longer-term version: schema-focused therapy (Young et al, 2003). It is worth acknowledging that critics of CBT did predict that it would eventually show signs of 'psychodynamic drift': reversion back to psychodynamic practice (Weishaar, 1993).

This brief review indicates that there is both difference and similarity amongst the therapeutic models' approaches to the therapeutic relationship. All therapies have stressed the importance of the therapeutic relationship and the differences may be hard to fully articulate in the sort of simple one line statements of principles used here.

2.9: Principle 9: CBT is a collaborative effort by client and therapist

Collaboration means simply 'working together' and, as such should prove the least controversial principle as client and therapist must surely have to work together in some way for effective therapy to occur. Yet, for many, 'collaboration' carries some extra meaning that is associated with a more equal and democratic way of working. This kind of therapeutic relationship is most associated with the person-centred model of Carl Rogers (1967; 1980). Rogers took much inspiration from Martin Buber, especially from his distinction between 'I-Thou' relationships and 'I-It' relationships. Yet when Rogers and Buber conducted a famous dialogue, Buber would not agree with him that the therapeutic relationship was an equal relationship (Kirschenbaum & Henderson, 1990). Buber agreed that therapy had to have moments of the 'I-Thou' dimension and yet did not

agree that it should be an equal one in its entirety. Agreement and disagreement with this principle may turn on the exact meaning being attributed to the nature of collaboration.

2.9.1: The rationale for collaboration in CBT

Beck (1991b, p. 194) suggests that the collaborative relationship goes beyond the core conditions described by Rogers:

> I certainly consider the therapeutic alliance as a common factor shared with other therapies. But I also believe that the shared and explicit focus on changing belief systems, reinforcing and refining reality testing, and developing coping strategies make for a more robust therapy.

CBT uses factors that are common to many other therapies, but is more specific in how such factors are used. Alford & Beck (1997) argue that cognitive change is the active ingredient of many of the 'common factors' amongst psychotherapies. CBT aims to produce the same outcome as other types of therapy but by a more direct route. Such work is achieved by means of developing a collaborative relationship and collaborative empiricism (Beck and Emery 1985, p. 175):

> The cognitive therapist implies that there is a team approach to the solution of a patient's problem: that is, a therapeutic alliance where the patient supplies raw data (reports on thoughts and behaviour...) while the therapist provides structure and expertise on how to solve problems. The emphasis is on working on problems rather than on correcting defects or changing personality. The therapist fosters the attitude 'two heads are better than one' in approaching personal difficulties. When the patient is so entangled in symptoms that he is unable to join in problem solving, the therapist may have to assume a leading role. As therapy progresses, the patient is encouraged to take a more active stance.

Collaborative empiricism helps the therapist to 'get alongside' the client. The work of 'attacking' client's problems is not experienced as an attack on clients themselves:

> It is useful to conceive of the patient–therapist relationship as a joint effort. It is not the therapist's function to reform the patient: rather his role is working with the patient against 'it', the patient's problem. Placing emphasis on solving problems, rather than his presumed deficits or bad habits, helps the patient to examine his difficulties with more detachment and makes him less prone to experience shame, a sense of inferiority and defensiveness. (Beck, 1976, p.221)

Beck & Emery (1985) spell out two practical implications of this stance: firstly, the therapy relationship develops on a reciprocal basis. Both therapist and client are working together to observe and comment on the clients' ways of being, to offer solutions to the problems and difficulties facing them. When the client cannot see a way forward, or an alternative to his thoughts or beliefs, the therapist may be able to offer a different view to the client. Similarly, the client can see and offer to the therapist another perspective. Secondly, this approach avoids hidden agendas. CBT is an explicit therapy. The therapist does not form unshared hypotheses about or interpretations of the client. The aim of therapy is made explicit. If client and therapist are working to different agendas, then it is likely that therapy will not proceed smoothly. A collaborative spirit gives a reflective, reciprocal quality: with therapist and client taking roughly equal time to speak.

The spirit of collaboration may be most clear when it is absent: when, for example, the therapists tell clients what to do or think. Therapists may become overly directive - not always from authoritarian intent, but often from a genuine desire for the client to get to a better place. In true collaboration, however, the therapist is willing to help the client without being patronising or disempowering. In developing a good therapeutic collaboration, therapists should be empathic and non-judgemental. The process of developing such a collaborative relationship involves working with the client to set goals for therapy, determine priorities, and maintain a therapeutic focus and structure.

Collaboration is expressed in many of the activities of CBT. At the first meeting, CBT is explained and its rationale discussed. Therapist and client work together to identify simple yet meaningful goals across therapy, such as 'being able to go out and see friends' or 'get back to work.' Mutual agreement on the nature of the problems is striven for. Collaboration is also built into the structure of sessions:

Figure 2.1: CBT Session Structure (Beck, 1995)

1. Brief update and check on mood.
2. Bridge from previous session.
3. Setting the agenda.
4. Review of homework.
5. Discussion of issues on the agenda.
6. Final summary and feedback.

Setting an agenda, for example, ensures that the client is consulted over what should be discussed at the start of each session. 'Bridging' also allows the therapist to ask if any issues have been left over from previous sessions before beginning the present one. Finally, at the end of each session, the client is consulted about appropriate homework assignments and asked to give feedback about how the session has just gone. These activities are always part of a CBT protocol (Beck et al, 1979; Beck & Emery, 1985; Beck, J., 1995; Wells, 1997; Holland & Leahy, 2000). Cognitive behaviour therapists aim to weave collaboration into the therapy structure so that a kind of collaborative 'rolling contract' is made with the client (Wills, 2006). The process of regular feedback, summaries and reflection also sets a collaborative tone, both therapist and client thinking about what is going on in therapy. Guided discovery is a collaborative way of working, enabling the client to find answers and different ways of seeing them without the therapist appearing to be the expert or becoming didactic. The aim is to encourage clients to be active in therapy so that they see themselves as having a central role in the decision making progress. Information and skills are shared, aiming for the client to become their own therapist.

2.9.2: Collaboration in other therapeutic models

We have already noted that collaboration in CBT does not imply 'equality' in the therapeutic relationship. The two roles are seen as distinct and the therapist is expected to have some 'expertise' in areas relevant to the client, though it is for the therapist to make that the general expertise count in this particular situation. The notion of expertise is a dubious one to many humanistic counsellors who are rightly concerned about the potential for power imbalance between client and therapist. Even in the person-centred model, however, the therapist clearly has a different role from that of the client. It may ultimately be only a value judgement that attributes more importance to one or the other role. In actual fact, neither role can succeed without the other. The main motivator here may be the desire to avoid 'medical models', as noted earlier. This was a key concern of Rogers, who was an astute political player in the struggle against medical hegemony of the therapy field during his years of practice (Rogers & Russell, 2002).

Humanistic therapists would also be likely to react against the hegemony of psychoanalysis in the therapy field. The hegemony of psychoanalysis was related to that of the medical model because for many years it was difficult for non-medical people to become psychoanalysts. One of the criticisms traditionally made of psychoanalysts was that they were 'experts' who were relatively immune from feedback from their clients (Crews, Ed., 1998) and, even at times, colleagues (Gabbard, 2005). Gabbard, himself a psychodynamic trainer, gives the following example:

> I once attended a case conference where an anxious resident (i.e., trainee psychiatrist) was presenting a case to a distinguished visiting professor. The resident commented that the patient came into the session and she said she needed to have her brakes checked before she drove home. The visiting professor interrupted the presenter and said with sweeping authority, "She's afraid that she's going to kill her husband." Many of the residents reacted with awe at the omniscience of the consultant and wished that they would someday be able to read minds as well as he could (Gabbard, 2005. p.336).

Gabbard (2005) presents example as the wrong way to teach psychodynamic therapy and a feature of modern psychodynamic approaches is that they have stepped back from such over-interpretation (Lomas, 1987). Perhaps a problem with the notion of the 'unconscious' has been that it may negate the client's conscious contributions as being fully valid (Beck, 1976). So for traditional psychoanalysts, it is easy to acknowledge an 'expert' role but may be more difficult to acknowledge the extent to which a client may make a significant contribution by collaborating with such expertise. The possibility of 'disempowering' clients has been, however, deprecated by more recent writers within this tradition. Lomas (1987; 1994; 1999), for example, has argued that this aspect of psychoanalysis may have resulted in psychodynamic therapists over using interpretation to the detriment of their clients. Jacobs (2004) has also criticised over interpretation in psychodynamic practice and argued the case for a more open – and in effect collaborative – approach to the work.

Humanistic therapists expressing concern over therapists acting as 'experts' may fail to distinguish clearly enough between power and authority (Gerth & Mills, 1991). The client can be seen as giving limited authority to the therapist by seeking his help. Furthermore, client surveys show that clients regard expertise as being a key element that they are seeking in a counsellor (Strong & Matross, 1973).

To summarise, the element of power given to CBTs therapist by the structuring of sessions is balanced by the use of collaborative elements throughout the therapy. It may be that therapists from other schools are not so aware of these safeguards and may become less concerned about elements of CBT that appear to them to be 'disempowering' of clients if they come to see these elements as offering protection against that.

2.10: Principle 10: CBT is based on the cognitive model of the emotional disorders

2.10.1: The development of and rationale for cognitive models of psychopathology

The importance attributed to cognitive models of psychopathology is shown by the fact that it is the first of the criteria that was offered for a system of psychotherapy earlier (Alford & Beck, 1997). Such a system should have:

> A comprehensive theory of psychopathology that drives the structure of psychotherapy ... (p.7)

Clark (1996) describes the characteristic processes by which Beck's cognitive therapy has developed comprehensive approaches to models of psychopathology. He locates the development of cognitive behavioural models - specific models particular to specific disorders - in the early steps of Beck's work on depression. The process has been greatly refined as CBT has expanded in terms of the numbers of practitioners and researchers involved in the multifarious treatment areas in which it is now participating. Clark describes the process as having 5 characteristic stages:

1) Moving from clinical insight to specify a simple clinical model for a particular problem area.
2) Experimental investigation of the model.
3) Detailed accounts of factors that prevent cognitive change in the absence of treatment.
4) Carefully chosen treatment procedures for targeting cognitive change.
5) Controlled trials of the effectiveness of those procedures.

Clear overlap can be seen between criteria establishing the validity of cognitive therapy (comprehensive theory with empirical support and efficacy research supporting its interventions) defined by Beck and the above stages described by Clark.

Beck (Beck & Alford), 1997):	**Clark (Salkovskis, Ed., 1996):**
Comprehensive theory of psychopathology that supports structure of therapy.	Stages 1 & 4 above
Knowledge & empirical findings that support the theory.	Stages 2 & 3 above
Research findings supporting efficacy.	Stage 5 above.

An account of these stages will be given in the context of the development of CBT for Panic Disorder. Panic Disorder is chosen because it has been acknowledged as one of the clearest current application models of CBT (Rachman, 1997a). It also has strong supporting evidence of construct validity and efficacy (Eysenck, 1997). In reviewing CBT treatment of Panic Disorder, Rachman (1997a, p.110) says:

> To summarise, the cognitive theory has exceptional explanatory value and has garnered a good deal of support. It has generated a form of therapy that is demonstrably effective. Moreover, there is no satisfactory explanation for the success of this therapy other than the cognitive theory itself. The coherence between the theory and its clinical applications is an added strength. Moreover, we now have a reasonably good idea why and when panic episodes are likely to occur. Any setting or prompt that increases the opportunity for catastrophic interpretations, or that increases the opportunity for a misinterpretation of an internal or external threatening stimulus occurring, will raise the probability that the person will experience an episode of panic. Significant changes in the number and intensity of relevant bodily sensations and/or a strong tendency to interpret these sensations as indicators of imminent danger can promote panics. We also know that although everybody experiences changing bodily sensations of the type that can provide an opportunity for catastrophic misinterpretations, very few people make the misinterpretations that induce a panic.

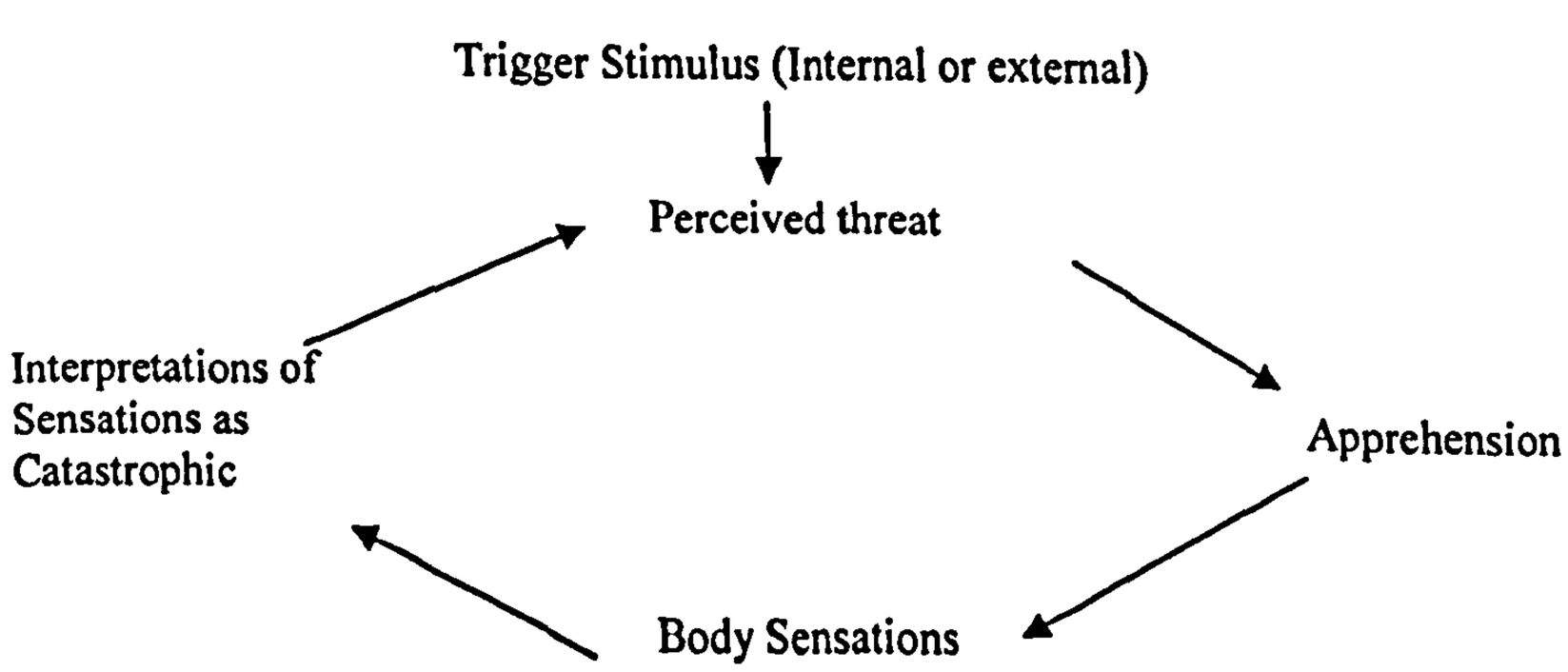
It is important to note that although cognitive theory emphasises role of cognitive processes in the development of psychological problems, this does not mean either that it argues that cognitions are causative or that environmental factors are not influential (Weishaar, 1993). Beck's model is clearly a 'stress-diathesis' model and recognises that the aetiology of psychological problems is multi-factorial and includes social and environmental factors (Weishaar, 1993). The cognitive approach to panic is one that offers exceptional degrees of fit between theory, practice and efficacy.

2.10.2: The development of the cognitive behavioural model of panic

The original ideas for cognitive therapy came from Beck's clinical insights during treatment: for example, the discovery of 'negative automatic thoughts' from a breakdown of communication with a particular patient (Beck, 1976). Beck's insights were formulated into a series of propositions - for example and in particular, *cognitive specificity*: a concept whose validity was subjected to test and research (Beck, 1967, 1976). The cognitive specificity concept posits that different types of psychological symptoms are specifically linked to characteristically negative patterns of cognition: for example, anxiety symptoms are linked to fear of future danger whereas depressive symptoms are linked to thoughts about past loss and failure. Clark and Steer (1996) review evidence for the 'cognitive specificity hypothesis' from 21 studies from 1978 and 1994. The cognitive profile of anxiety disorders did not emerge as clearly as the theory would predict, though Panic Disorder was highly specific and could be reliably distinguished from both any kind of depression and from Generalised Anxiety Disorder (Clark et al, 1994).

Panic Disorder is estimated as one of the most prevalent, disabling and costly to treat psychological problems reported in primary medical care (Roy-Byrne et al, 2005). Panic attacks are regarded as "ubiquitous" in anxiety and are reported as the commonest symptom co-morbid with the other anxiety disorders (Clark, 1986). Panic disorder is frequently a problem of sudden onset and is often experienced as coming without a clear precipitant. It is generally accompanied by strong physiological symptoms, such as breathlessness and increased heart beat. It may be accompanied by agoraphobia – the fear of being into public places - here the precipitants are more recognisable.

Figure 2.2- The suggested sequence of events in a panic attack (Clark, 1986)



Clark's cognitive model states that:

> Individuals who experience recurrent panic attacks do so because they have a relatively enduring tendency to interpret certain bodily sensations in a catastrophic fashion. The sensations that are misinterpreted are mainly those involved in normal anxiety responses.... The catastrophic misinterpretation involves perceiving those sensations as much more dangerous than they really are, and, in particular, interpreting the sensations as indicative of an *immediately impending* physical or mental disaster - for example, perceiving palpitations as evidence of an impending heart attack (Clark, 1988, p.149).

It is sometimes argued that Panic Disorder has a biochemical base or has been learnt by conditioning. The biochemical argument has been based mainly on the successful use of selective serotonin re-uptake inhibiting (SSRI) medication. This argument has, however, failed to provide a convincing causal theory, especially as it cannot account for the efficacy of purely psychological therapy (Rachman, 1997a). The cognitive behavioural explanation, however, is that the Disorder is caused by the 'enduring tendency to misinterpret' described earlier. It could, however, be that these cognitions are 'epiphenomena' - i.e., associated with Panic but not causally. The cognitive theory has therefore been built by testing each component part of the underlying concepts of the model as thoroughly as possible.

Clark (1996) suggests that there are 4 central and testable predictions of the model presented above:

a) Panic Disorder patients will be more likely to have catastrophic interpretations of bodily symptoms than individuals who do not experience panic.

b) Procedures that activate catastrophic misinterpretations will produce an increase in anxiety and panic in panic patients.

c) Reducing the patient's tendency to make catastrophic misinterpretations can prevent panic attacks.

d) Sustained improvement after the end of treatment will depend on whether cognitive change occurred during the course of therapy.

For prediction a) to be confirmed, it is necessary to establish that there is a correlation between catastrophic misinterpretation of bodily symptoms and the occurrence of Panic Disorder. It is also necessary to go beyond establishing this correlation because correlation does not in itself establish causality: for example, the misinterpretations could be epiphenomena. Predictions b), c) and d) were developed to provide this extension. Prediction b) aims to remove some of the limitations of retrospective 'self-reports' by prospective studies of intentionally generated panic attacks. Prediction c) seeks to establish causation by manipulating misinterpretations and then observing whether the changes predicted by the model occur. Prediction d) extends the causal chain beyond immediate recovery to estimate the on-going causal power of both the presence and absence of misinterpretations in the longer-term post-treatment phase. Clark (1996) presents exhaustive evidence to show that these predictions have been thoroughly tested and found to be confirmatory of the model.

2.10.3: The efficacy for CB treatment for Panic Disorder

The studies already described have included various cognitive and behavioural manipulations of the type used in CBT. These manipulations were developed in CBT interventions and then tested as protocols in randomised clinical trials (RCTs). RCTs are regarded as the 'gold standard' for research findings in many quarters (Parry & Richardson, 1996), though this view is not without critics (Roth & Fonagy, 1996; Rowlands & Goss, 2002).

Systematic reviews for the treatment of panic frequently take the form of meta-analyses. Meta-analysis is a procedure that considers data from separate studies collectively. It calculates an effect size for each study by way of the formula:

$$\text{Effect size} = \frac{M1 - M2}{SD}$$

M1 is the mean improvement of the treatment group, M2 is the mean improvement of the control group and SD is the standard deviation of the pooled variance. This statistic allows for the determination of Z-scores, allowing the aggregation of different types of measure. Although meta-analysis is a powerful research tool, its power is dependent on

consistently good decisions being made about allowing data from studies with sound validity into the analysis (Rowlands & Goss, 2002).

Furukawa et al (2007) conducted a systematic review on panic disorder for the Cochrane Database. They reviewed the efficacy results for trials involving psychotherapy, predominantly CBT, with and without antidepressants in the treatment of panic disorder, with and without agoraphobia. They identified 23 randomised comparison studies, 21 of which involved behavioural or cognitive-behavioural therapy. In the acute phase, combined therapy was superior to antidepressant pharmacology alone or psychotherapy alone. The combined therapy produced, however, more dropouts due to side effects than psychotherapy. After the acute phase, as long as the drug was continued, the superiority of the combination over either mono-therapy appeared to persist. After termination of the acute phase and the commencement of continuation treatment, the combined therapy was more effective than pharmacology alone and was as effective as psychotherapy. The plain language summary concludes (Furukawa et al, 2007, p. 2):

> Either combined therapy or psychotherapy alone may be chosen as first line treatments for panic disorder with or without agoraphobia, depending on client preference.

The cumulative effect of studies of CBT treatment of Panic Disorder has meant that it is now regarded as a strong example of how the researched and tested cognitive model of a disorder can provide an invaluable template for the practitioner. Such a template gives information that the practitioner can use to assess and understand the client and to plan interventions in such a way as the chances of success are maximised. Rachman (1997a, p. 111) comments:

> Leaving aside these challenging theoretical questions, the growing potency of CBT is extremely welcome and clinicians are well placed to provide effective help for many people and to do so with well-grounded confidence. In the studies reported over the past seven years, the percentage of patients who were left free of panics ranges from 80-90% - an unprecedentedly powerful method.

Whilst the overall efficacy of the CBT for panic has been well demonstrated, there are still questions regarding the effective elements of the intervention. Shear et al (1994) followed a similar logic to that of Beck et al (1992) by comparing CBT to non-prescribed

therapy, a form of non-directive therapy designed to control for the effects of the therapeutic relationship but reported no significant differences between the two conditions.

Basoglu et al (1994) & Van den Hout (1994) both attempted 'dismantling' studies to partial out the different effects of CBT treatment for Panic Disorder and for Agoraphobia. They came to the conclusion that Panic Disorder and Agoraphobic symptoms improve relatively independently. This and other findings have led to current UK treatment guidelines advising different interventions for Agoraphobia - exposure - and for Panic Disorder - cognitive therapy. Their conclusions are admirably summed up in the title of Van den Hout et al (1994)'s paper, 'Exposure reduced agoraphobia but not panic, cognitive therapy reduced panic but not agoraphobia.' It is, however, notable that these differences on how agoraphobia influenced outcome are not discussed by Furukawa et al (2007).

Durham et al (2005) have conducted follow-up interviews with patients who had suffered from panic and other anxiety disorders between 2 and 14 years after CBT treatment. They point out that whilst CBT is undoubtedly effective in the short term, the longer term effects have not yet been demonstrated. It appears that there is a group of patients with persistent problems who do frequently return for ongoing and sometimes lengthy further treatment. Psychodynamic critics such as Busch (2006) have suggested that although CBT may tackle panic symptoms effectively, this does not rule out that other more deeply seated problems may be left untouched. This critique may point toward client issues that are more schema-focused. With reference to this point, it is worth noting that Milrod et al (2007) report a successful randomised trial of psychodynamic therapy for panic disorder. Milrod et al (2007) argue that psychodynamic therapy might prove particularly useful for clients with long term developmental issues that connect to their panic symptoms.

2.10.4: The place of the schema concept and formulation in cognitive models

It can be observed that most of the theoretical and efficacy work detailed above describes the maintenance cycle of current functioning of the disorder. It does not describe how

such current functioning may be linked with the client's developmental history and childhood experience, though sometimes suspected general links with types of childhood experience are described elsewhere (Salkovskis et al, 1998). The therapeutic work equally focuses on that cycle. Underlying vulnerabilities associated with panic disorder are neither described nor worked upon in the Clark's (1988) treatment plan.

Fundamentally the underlying vulnerabilities of psychological disorders have been much harder for cognitively based research to identify.

The guiding concept that has been used in the research on vulnerabilities has been that of schema. This concept has proved a controversial one. The schema concept has been taken into CBT case formulation (Persons, 1989; Beck, 1995). Case formulation is a method that is increasingly used across the range of psychotherapy models (Eells, 1997) and Persons et al (1996) have argued that CBT idiographic formulation that can incorporate early experience via the schema concept makes the CBT model less aversive to psychodynamic therapists. Two different emphases on formulation, however, are evident in CBT: firstly, general 'problem based' models, such as Clark's theory of panic, that typically are not hypothecated on schema descriptions and, secondly, idiographic formulation, including schema descriptions, of the problems of individual clients. This section will therefore review the schema concept and then describe some current discussions about formulation in CBT.

Commentators such as Brewin (1988, 1996) and Eysenck (1997) have appraised the schema concept as having face validity. They have also, however, noted that the concept has proved difficult to validate scientifically. Eysenck (1997) suggests that there are 3 main problems faced by schema theory:

1) The amorphous nature of the definition of a schema. It is, for example, quite difficult to define the difference between a belief and a schema.

2) The existence of schema is often based on a circular argument. Cognitive biases are sometimes claimed as a by-product of schemas and sometimes as an influence on schemas.

3) Schema-congruent processing in anxiety disorders is markedly less evident than schema theory would predict.

Wells (1997) reviews the evidence that supports schema theory in relation to anxiety, mainly from two sources - retrospective self-report studies of patient populations and experimental studies of anxiety patients and non-anxious control patients.

Retrospective studies of patient populations (Ottaviani & Beck, 1987, Beck et al, 1987) show the cognitive biases predicted by schema theory. There are, however, a number of methodological difficulties with these studies. Firstly, they are over-reliant on self-reports, which are known to limit the validity of data (Wells, 1997). Secondly, it is very difficult to tease out the degree to which schema-congruent results occur mainly during the acute phase of the disorder - when compared to the chronic and recovery phases. Cognitive avoidance is a particularly marked feature of the anxiety disorders and may mean that fears may be unacknowledged in client self-reports.

Researchers have tried to circumvent these difficulties by devising experiments with covert measures of biases and, particularly in relation to anxiety, hyper-valent attention in information processing tasks. The principal methods used in information processing tasks are encoding tasks, filtering tasks, dot-probe detection tasks and Strop tests (Wells & Matthews, 1994). By way of illustration, a typical filtering task is the dichotic listening test. Participants are given headphones that present different word signals in different ears. The participant is asked to pay attention to and perform tasks related to one source only. This source presents neutral words whilst the other source contains many threat-related words. It is assumed that if participants pay attention to the other source of words, their performances on the tasks will deteriorate. Mathews & McLeod (1985) found that anxious participants performed less well than non-anxious participants did. Both Wells (1997) and Eysenck (1997) conclude that a reliable bias effect has been shown in these studies, though others, such as McNally (1993) have doubted that these tests are ecologically valid in relation to the clinical field. Furthermore, they really only help us to conclude that the data are as they would be were schema theory valid.

Memory bias has been established in depression but the phenomenon appears much less stable in anxiety (Wells & Matthews, 1994). As Wells (1997) notes, "Individuals with anxiety show attention bias for schema-congruent danger information. Nevertheless, the underlying mechanisms for bias effects require systematic evaluation... However, questions of causality in the relationship between cognition and anxiety remain unresolved" (Pg.13-14).

We might summarise the evidence about the role of 'underlying causes' in CBT suggests that whilst there is good reason to be confident that the therapy works, it is not well understood how it works. This question at the heart of the therapy has led some researchers to try to redefine the schema concept. Prominent amongst these researchers is Teasdale (1996). In essence, Teasdale argues that the schema concept is liable to reification - to presentation as a thing, a 'structure' as previously quoted. In place of this, he argues that it should be seen as a relationship between different elements of functioning. He presents a 'network' concept of interconnecting subsystems that process affective, physiological, behavioural and cognitive information. He terms this network the Interacting Cognitive Subsystems (ICS) framework. It is informed by many research findings from his earlier work on tracing the way the affective, physiological, behavioural and cognitive systems influence each other (Teasdale & Barnard, 1993). The various subsystems, such as the propositional and implicational subsystems mutually influence each. There are, however, core elements in the whole system that act to synthesise cognitive products. These syntheses become especially powerfully effective and act as networks of persuasive information or schematic processing. Teasdale (1996) claims that the ICS concept is congruent with other leading attempts to provide a clearer definition of schema within cognitive theory. For example, Beck (1996) suggests that schemas might be better thought of as 'modes' - evolutionary network connections between the functioning systems similar to the ICS network concept described above. Anxiety is a particularly good illustration of network reactions based on evolutionary advantage that may become liabilities in everyday modern life (Beck & Emery, 1985). Teasdale claims

that the ICS concept is compatible with recent attempts to evolve CBT techniques more likely to lead disconfirmation of negative beliefs.

The extent to which the ICS concept will gain wide acceptance from CBT therapists remains to be seen. This uncertainty about underlying causal factors may be problematic to other therapeutic modalities, especially the psychodynamic model, that place such great stress on underlying, usually located within the client's early experience, causes.

Formulation in CBT owes a considerable debt to the behavioural tradition. Bruch & Bond (1998) acknowledge the role of the early British behaviourist, Meyer, (Meyer & Chesser, 1970; Meyer & Turkat, 1979)). Meyer was particularly concerned to counter the 'diagnostic' emphasis of the psychiatry of that time and wanted to replace it with an approach based on the individual client's learning history. Such an emphasis was also reflected in the work of the American behavioural therapist, Turkat (1985; 1990). Persons (1989) also built on the work of Turkat in bringing case formulation into cognitive therapy. Bruch & Bond (1998) are, however, critical of her work on a number of counts. Most notable for the discussion here is their assertion that in using the term 'underlying cause' she seems to imply '... some psychodynamic analogy, (rather than) attempt to formulate a valid *clinical theory.*' (p. 14)

In summary, there are ambiguities, and different traditions, within cognitive modelling and formulation making in CBT. Many questions remained as yet unanswered about CBT formulation, including:

- Is there any validity and usefulness for diagnosis group formulations?
- Is there and validity and usefulness for 'underlying mechanisms' in group or individual formulation?

Cognitive therapists would be likely to answer these questions with 'Yes' and 'Yes', person-centred and psychodynamic therapists with 'No' and 'Yes.' Behaviourists might well answer, 'No' and 'No.' It is, however, not clear to what extent even many CBT therapists appreciate that these subtle differences do exist within the broader church of 'CBT formulation.' Kuyken (2006) has suggested that more rigorous tests of formulations need to be developed.

2.10.5: The development of and rationale for cognitive models: an overview

It has been necessary to chart the rather precise and difficult paths through various, especially evidential, features of the rationale and development of cognitive models for several reasons:

- The power of the model is derived from establishing precise links between problematic thinking, emotions and behaviour,
- The appeal of the model to practitioners is often based on its empirical standing. Even if they do not always appreciate much of the detail of this, detailed research findings may be consulted.
- Health systems are increasingly managed on the basis of 'empirically supported' treatments. Even if the managers do not always appreciate much of the detail of this, again, the detailed research is available. All therapy models are increasingly required to find such evidence.

It is known that professionals in the field of psychological therapy have been as disinclined to read research evidence regarding the efficacy of their work as it seems are most other professional groups (Persons, 1995). Now that decision-making bodies in governmental and other health arenas frequently require more research evidence, it is helpful to be able to cite evidence that supports one's work. The CBT field has been unusually successful in combining the work of researchers and practitioners into unitary practices. It is probably the professional group in psychological therapy that has come closest to achieving the 'Boulder' model of the scientific practitioner (Hayes et al, Ed., 1995; Clark & Fairburn, 1997).

2.10.6: Specific formulation models in other therapeutic models:

In considering how other therapeutic models might regard this formulation principle, it is necessary to distinguish between how they might respond to the idea of having specific treatments geared to specific disorders and how they might respond to the idea of a specific cognitive treatment for a specific disorder.

How sympathetic might other modalities be to the idea that therapy should be specifically shaped towards different disorders? Both the person-centred and humanistic approaches offer some element of formulating psychological problems though the notion of psychopathology is inimical to person-centred therapists. McLeod (2003, p. 137) writes of the assessment process in humanistic therapy,

> Humanistic practitioners see little value in conventional approaches to psychological assessment. For example, any attempt to fit a diagnostic label to a client is likely to intrude into the relationship between client and therapist, and interfere with the task of understanding the client's experience from his or her point of view.

The main formulating element of Rogerian therapy stresses the value of 'unconditional positive regard' and a 'non-judgemental' attitude so highly that much emphasis has been put on the effect of significant others, especially parents, requiring that their children meet high 'conditions of worth' in their lives. For example, when parents expect too much of children and then judge their 'failure', this may damage the self-concept of the developing child. The highly accepting nature of the humanistic counsellor is supposed to counteract this negative influence and empower the client. Within person-centred counselling and therapy, there are few if any general models – for example, of depression. There has, however, been some recent work by Mearns & Thorne (1999) showing specific distortions of self- concept in relation to severe problems such as borderline personality disorder.

Within person-centred therapy, there is a great emphasis on the individual client and therapist building up an understanding of that client's unique view of the world. Johnstone & Dallos (2006, p. 11) note, "... not all therapeutic approaches use formulation as a starting point. Humanistic therapists have been reluctant to engage in a process that Carl Rogers (1951) saw as an unhelpful imposition of an expert point of view on the client's experiences..." Interestingly, one of the main early efficacy findings on person-centred counselling was in the meta-analysis by Smith, Glass & Miller (1980) that showed person-centred therapy had strong efficacy with problems with self- concept and low self esteem (Ivey et al, 1997). Problems with low self esteem are obviously often linked to other psychological problems.

This emphasis on the individual uniqueness in humanistic models may mean that, for people who come into training in CBT with a person-centred background, it is problematic to accept and work with cognitive formulations that demand knowledge of specific cognitive content and for the therapists to review individual client functioning in the light of such knowledge. Such an approach may have the double jeopardy of taking the role of 'expert' and of conspiring in the 'labelling' of clients.

Eells (1997) notes that psychodynamic therapy has always had an implicit notion of formulation and with the development of shorter term dynamic models, this has now become more explicit. Leiper (2006, p. 48) describes psychodynamic formulation as having strikingly different features from other models. Apart from having different core elements such as defence mechanisms, there is a strong element of 'not knowing' in psychodynamic formulation:

> Such a general way of looking at clinical material leaves a lot of scope for diversity in what an 'accurate' or even a simply useful, formulation might look like.

This type of 'diverse' formulation contrasts with the more definite and empirically based formulations of CBT. Trainees who enter CBT training already influenced by psychodynamic ideas may therefore be likely to be resistant to the general and symptom-focused models of CBT and are likely to be more influenced by individual explanations of the client focused on early experience. It was interesting to see the extent to which versions of CBT 'case formulation' that adapt a general clinical model of a disorder to the individual client (Beck, 1995) can satisfy this tendency toward individual case history within trainees with a psychodynamic background coming for training in cognitive behaviour therapy. Persons et al (1996) suggest that individual cognitive formulations are helpful in overcoming psychodynamic therapists' reservations about cognitive therapy.

Beck & Emery's (1985, p.87) definition of the formulation principle is "Cognitive therapy is based on the cognitive model of emotional disorders," whilst Judith Beck's definition is, "Cognitive therapy is based on an ever-evolving formulation of the patient and her problems in cognitive terms" (Beck, 1995, p.5). Historically, the difference between the two statements may reflect the influence of the 'formulation' (or 'conceptualisation') concept, which was implicit in Beck's earlier works but was made

explicit by Persons (1989). Formulation implies a greater consideration of the idiosyncratic situation of the individual client, though it would also build such understanding with the use of the general disorder models described above. The formulation concept perhaps marks a shift in position of CBT within the current range of psychotherapies and may show the ambition to appeal more to therapists who stress solely individual formulation, though the extent to which these activities are rooted in the more empirical approach taken by CBT researchers is, as noted above, controversial.

In summary, cognitive models for specific disorders, such as depression and anxiety, have played a central role in the development of CBT. Whilst these models offer advantages to the therapist, they do not necessarily preclude adaptation to a more individualised model for each client. Other therapeutic models do not have such a strong emphasis on generalised and disorder-based models and put more faith in individual conceptualisations. From a humanistic perspective, this individual emphasis is motivated by respect for the individual's frame of reference and by reluctance to 'label' the client. From a psychodynamic perspective, it may be motivated by a lack of faith in the client's *conscious* self-conceptualisation. The CB therapist's interest in generalised models may therefore be inimical to humanistic and psychodynamic therapists. This aversion may perhaps be tempered by the degree to which they can be induced to believe that the effects of the generalised models may be counter-balanced by use of the individual case conceptualisation process in cognitive therapy (Persons et al, 1996).

2.11: Conclusion to the Chapter

The main aim of this chapter has been to describe the distinctive principles of CBT and to explore the differences and similarities with the principles of two other psychotherapy models. This review reveals three broad trends:

1). Some quite sharp points of difference: for example, the significance of symptoms, the use of therapy structure, therapist directiveness and the emphasis of techniques in CBT.

2). Some evidence of convergence - especially where CBT has integrated ideas from the other therapies: for example, ideas regarding the therapeutic relationship and the use of longer term work with certain clients.

3). Evidence of increased therapy integration of CB concepts into some aspects of other models: for example in the use of homework and formulation.

2.11.1: Points of difference between CBT and other models

The main points of difference concern the foci of therapeutic interventions: variation on the foci on symptoms and on underlying mechanisms (for example, earlier negative learning and negative childhood experiences) and then of the consequent ways of working with these different foci. For CBT, symptom relief is a key objective for therapy and, indeed, in the event that underlying mechanisms do not become an intrusive problem, symptom relief may be regarded as the only objective for therapy (Layden et al, 1993). As CBT has expanded, however, underlying mechanisms have been targeted more, especially in the longer-term version of cognitive therapy: schema-focused therapy (Young et al, 2003). Symptoms are taken seriously in CBT. Therapeutic interventions are seen as needing relatively robust methods to overcome the effects of symptoms. This line of reasoning has been used to justify CBT's more structured and directed techniques (Dryden, 1998). Other models of therapy, however, tend to regard symptoms as having lesser significance than underlying mechanisms. Symptoms are therefore often ignored in relative terms and most of the therapist's effort is put into tackling underlying problems. The emphasis on the need to address underlying issues may be justified by an apparently one-way causal hypothesis: that the symptoms result from the influence of such underlying mechanisms and can therefore only be ameliorated by changing the underlying mechanisms. In CBT, in contrast, a reciprocal relationship between symptoms and underling mechanisms is assumed, so that working on the symptoms can ameliorate the underlying mechanisms. It is, for example, possible to learn to act as if one has the resources to cope with a dangerous world, even if one does not quite believe it. Over time, it is at least possible, though obviously not certain, that continuously behaving in such a way may lead to the inner beliefs that one does have the resources and that the world is perhaps not quite so dangerous, or to both.

In CBT, the therapeutic relationship tends to be defined as a vehicle in which the change mechanisms of the therapeutic work are carried forward (Feltham, 1999.) The change mechanisms in CBT usually involve structured and directed interventions. In other models of therapy, the therapeutic relationship is itself the change mechanism and the vehicle. Because so much emphasis is put on the therapeutic relationship, it is defined in very subtle terms. Structured and directed therapeutic work tends to be seen as contravening the subtlety required to sustain the relationship.

With regard to the areas researched by this thesis, there is a noticeable difference in the nature of some arguments against CBT. Some such arguments may be termed 'criticisms', for example, that clients will feel demeaned by being set homework. These criticisms may be explored at least in principle via resort to evidence: how do clients report the experience of doing homework? Other such arguments may be more accurately termed as 'reservations' – for example, that CBT does not place enough emphasis on the interpersonal relationship between therapist and client. These arguments may be much harder to work through because they relate to more intangible questions: for example, how much emphasis is 'enough'? The intangibility of the 'reservation' may help to keep them more impervious to change.

2.11.2: Points of convergence

Beck has expressed the hope that CBT will gradually cease to exist as a separate school of therapy (Salkovskis, 1996, p.538). Beck hopes that, "... what we call cognitive therapy (conceptualisations and treatment plans informed by research, collaboration, and guided discovery) will be taken for granted as the basics of good therapy, just as Carl Rogers's principles of warmth, empathy, and genuine regard for patients were adopted as necessary basics of all therapy relationships."

One of the features of writing this review that has surprised the author has been the degree to which this has already begun to happen. For example, a striking number of brief treatment models are developing across all the modalities. These models all tend to use formulations, structured interventions and homework. Part of the reason for this has been

the pressure for short-term work and evidence-based practice in USA, UK and world wide, mentioned earlier. Despite this pressure, there has been an increase in psychological therapy services offered within the UK health care system. There has also, however, been an even bigger increase in demand (Parry & Richardson, 1996). A series of large-scale recent studies of counselling in the NHS (Bowers et al, 2000; Chilvers et al, 2001) have shown that counselling has become the most popular treatment for anxiety and depression with patients in primary care. If psychological therapy is to reach down into services for the general population, it is clear that this can only be achieved by relatively short-term therapies in the foreseeable future.

2.11.3: Therapy integration

Beck has also expressed the hope that CBT might be a vehicle for the achievement of a wider integration of all the therapeutic models (Alford & Beck, 1997). There is a very active interest in therapy integration and many therapists report that they practice some kind of integrated or eclectic form of therapy (Eells, Ed., 1997). The most active area where there is evident is in the development of brief therapies. As discussed above, the methods and techniques of CBT appear to have had a great impact in the field of brief therapy. It is, however, also evident that when writers describe their theories in more formal terms, very few allusions are made to integrating concepts from CBT, whereas descriptions of CBT frequently contain allusions to integrating items from other therapies (Woolfe & Dryden, 1996). This may be because clinicians have dominated the development of the short-term therapies. As Brewin (1996) notes, it frequently takes theoreticians some time to catch up with and provide theoretical explanations for the developments of clinicians.

2.11.4: Summary:

A series of competing ideas have evolved to explain the processes of psychopathology and its therapy. Some ideas have been in sharp contradiction of each other, other ideas appeared so close that they have led to the hope of an overarching integrated theory emerging. This variation in debating style may explain why debaters in different eras have referred to both 'Cold War' (Norcross & Arnkoff, 1992) and 'post-tribal' (Inskipp,

1996) relations between the models. It has been difficult to avoid debates between the therapy models that over-emphasise either difference or similarity. The approach of this study has therefore been to try to define principles of theory and practice as precisely as possible and to then compare how such principles might appear to proponents of other points of view. Our review of the principles of CBT suggests we can hypothesise that trainees who, on the one hand, strongly hold to opposite principles will experience abnormally high degrees of dissonance when trying to learn CBT. On the other hand, however, they are not likely to hold equal reservation about all CBT principles. The study aims to further explore this area by identifying the combinations of attitudes to particular principles held by trainees. As the principles impact on performance of practice skills, we might also hypothesise that different combinations of attitude towards CBT principles would impact on CBT skill learning in general or specific ways. These hypotheses are tested in the remaining chapters of this study.

Chapter 3: Skills training for CBT

Training for psychological therapy involves educating students in using skills, theory and practice in a competent and effective way (Ivey et al, 1997). Given the different approaches to practice, trainers must decide whether to train students in the skills, theory and practice of just one of the main paradigms, more than one of them or all of them. In practice, current accreditation systems require that a student is rigorously trained in at least one approach but usually also require that students are introduced to the other main approaches. The British Psychological Society (BPS) for example, requires that its chartered counselling psychologists should be introduced to all the main approaches and should be proficient in at least two of them. Private training institutions tend to be centres for particular approaches and remain as bastions for mono-therapy models. Public institutions more regularly offer at least some introduction to different models and are more likely to have staff members trained in different traditions. It can be seen, therefore, that training frequently takes place against the background of different paradigms and most trainees will have at least some introduction to a range of different and, in some ways, competing ideas. Therapists from one particular theoretical background may therefore need to train in another. Mackay et al (2001) for example, describe the experiences of counsellors trying to change from mainly person-centred to psychodynamic-interpersonal practice. The counsellors reported various difficulties in making these changes including realising that they sometimes tried to adhere too strictly to the new model and this often had negative effects on their practice. This chapter will describe the development of skill training in counselling and psychotherapy and will review studies of trainees who have been changing from other models into CBT practice.

The balance between the elements of skills, theory and practice has varied over the history of training of psychological therapists and has also varied within and between the different main approaches. Early attempts at psychoanalytic training were mainly based on didactic teaching of theory and case study based practice teaching – with accompanying personal analysis and supervision by a mentor figure. More emphasis was put on skills and techniques as the opportunities for easily recording therapeutic sessions increased. CBT therapists and trainers have embraced this technological development

most enthusiastically, and, characteristically, have developed widely used skills measures, such as the CTS-R., and numerous therapy manuals to guide interventions and skills. Psychodynamic and humanistic trainers, emphasising relationship over technique, have expressed more reservations about the skills based approach. Skills-based training is used and some therapy manuals and skills measures have evolved, however, even in some areas of training for both psychodynamic and humanistic therapy. Training can therefore be an area of both cooperation and conflict between the different approaches. One solution to conflict is to have completely separate institutions, as exist in the case of some private training agencies. This solution may not be available to public institutions, which can therefore be subject to the forces of both cooperation and conflict between approaches. Trainees may therefore be subject to a variety of different influences that may impact on their attitudes towards practicing therapy and these attitudes may influence the learning of skills, theory and practice.

3.1: Skills and training for psychological therapy:

General definitions of 'skill' have stressed three main features (Concise Oxford English Dictionary: Soanes & Stevenson, Eds., 2004):

- Skilled activities are identified as being performed expertly or well,
- Skilled activities are performed with 'dexterity' or smoothness,
- Skills are developed as a result of training or experience.

Skilled activities showing expertise and smooth execution still, however, need to be conducted in a way that is appropriate to the objectives of the overall activity of which they are a part and to the context to which they pertain. Underpinning knowledge should enhance appropriateness. When skills are so performed, the person performing them may claim to have competence. Competence is often seen as an indication of adequate qualification to perform certain tasks. Competence may be understood as a general or particular attribute of a person's performance (Concise Oxford English Dictionary: Soanes & Stevenson, Eds, 2004):

> 1a. The state or quality of being adequately or well qualified: ability.

1b. A specific range of skill, knowledge or ability.

Skills and competencies in counselling and psychotherapy have been more actively defined since the 1970s and have often been linked with certain sorts of proactive attitudes in psychology such as self-efficacy and 'intentionality'. Ivey, (1987, p.11) locates skills as central to the intentional practice of counselling and psychotherapy:

> Intentionality is acting with a sense of capability and deciding from a range of alternative actions. The intentional individual has more than one action, thought or behavior to choose from in responding to changing life situations. The intentional individual can generate alternatives in a given situation and approach a problem from different vantage points, using a variety of skills and personal qualities, adapting styles to suit different cultural groups.

Making intentional choices involves choosing from a range of theoretical ideas and concepts, usually during training. Skill and competence learning in counselling and psychotherapy has progressed from a preoccupation with the relatively abstract discussions with a mentor figure associated with early attempts to establish training to the more precise definition of skills. The subsequent development of 'micro-skills' teaching and learning (Ivey, 1987) fed naturally into the development of therapy manuals and protocols and these have played a central role in the search for more consistently effective psychotherapeutic practice and 'evidence based practice' (Roth and Fonagy, 1996). It is helpful to distinguish between different skill areas and Ivey et al (1997) note that different therapy models will emphasis different skill areas, see Figure 3.1.

Figure 3.1 below shows that the skill profile for CBT is distinctly different from that of person-centred and psychodynamic therapy, which are more like each other with a particular focus on relationship skills. The CBT model has been criticised for a narrow focus on techniques (Weishaar, 1993) but actually CBT theorists have tended to specify three broad areas of practice skills already described: technical, formulation and relationship (Sudak et al, 2003; Bennett-Levy, 2006). Figure 3.2 below shows some specifications of the skills in these broad areas

Figure 3.1: Skill use in different therapy models (Adapted from Ivey et al, 1997)

	Person centred therapy (PCT)	Psychodynamic therapy	CBT
ATTENDING SKILLS			
Open questions			
Closed questions			
Encouragers			
Paraphrase			
Reflection of feeling			
Reflection of meaning			
Summarising			
INFLUENCING SKILLS			
Feedback			
Advice/information			
Self-disclosure			
Interpretation			
Logical consequences			
Directives			
Influencing summary			
Confrontation			
FOCUS OF WORK			
Client			
Therapist			
EXTENT OF THERAPIST TALKING			
ISSUE OF MEANING	***Feelings/ relationships***	***Unconscious motivation***	***Unhelpful cognitions***

Key: **Green space** = Little use; **Blue space** = Some use; **Red space** = Much use

:

Figure 3.2: CBT skill and personal quality areas as defined by various CBT writers:

	Beck & Young (1985)	**Dobson & Shaw (1993)**	**Padesky (1996)**	**Sudak, Beck & Wright (2003)**	**Bennett-Levy (2006)**	**Roth & Pilling (2007)**
Relationship skills	Non-specific skills of genuineness, sincerity openness. Be skilled at seeing events through client's perspective; be able to suspend own assumptions and biases whilst listening to patient describe reactions and interpretations.	Ability to tolerate the client's negative emotions. NB: Consider that relationship skills may be 'immutable': i.e., cannot train people in them.	Highly interactive, sensitive to adapting therapy to individual client to maximise collaboration and positive therapeutic relationship.	Develop a strong active and collaborative therapeutic alliance. Work on treatment compliance.	Reflection skills: E.g.: I notice that my client is feeling negative about me asking him to do this activity schedule.	Generic therapeutic competencies: Ability to engage client; Ability to maintain a good therapeutic relationship; Ability to deal with emotional content in sessions.
Formulation skills	Reason logically and elicit a more convincing interpretation of the same events; plan several steps ahead, anticipating the desired outcome.	'Psychological mindedness': committed to learning; no strong commitment to another school of psychology; relative inexperience.	Comfortable tracking a number of tasks at the same time within a session.	Formulate cases according to cognitive model; use formulation to plan sessions; monitor progress;	Procedural skills: E.g.; Now would be a good time for an activity schedule – it is early in therapy but we have a good relationship already.	Ability to formulate maintenance cycle and use to set targets; Ability to develop formulation & treatment plan; **Problem specific competencies**: for e.g., panic. **Meta-competencies**: Such as clinical judgement & applying formulation to individual clients.
Technical skills	Be active; provide structure and direction to the therapy process.	Preference for active rather than passive therapeutic stance.	Capable of being highly structured in therapy.	Structure sessions to maximise progress; Problem solving; identify negative cognitions; facilitate behavioural change; Relapse prevention.	Declarative knowledge skills: E.g.; An activity schedule could help this depressed client by activating him.	Ability to structure sessions; Ability to implement CBT using a collaborative approach.

3.1.1: The Impact of Recording Equipment

Blocksma and Porter (1947) studied adherence to non-directive method during client-centred training. They found that trainees vastly over-estimated the degree to which they followed non-directive practice. The study was possible because of the advances in the ease and cost of making recordings of therapy sessions and the willingness of Carl Rogers to use such technology in the development of therapy. Recording equipment allowed sessions to be recorded in a more accurate fashion: successively on 78-rpm records, film, audiotape, and, later, videotape, CD, DVD and MP3 formats. Audio recording is the least intrusive of these methods and played a major role in the research work of Carl Rogers (1942; 1951; 1967; 1980).

A main thrust of Rogers' approach to therapy was to understand clients in terms of their own 'frames of reference' by listening carefully to them and showing empathy. Rogers (1980, p. 139), however, later referred to the "appalling consequences" that came from developing mechanical skills from his work. Such skills, referred to as 'listening skills' and 'empathic skills' are now in common use amongst therapists of all types and are often taught on training courses. They may involve specific techniques such as 'paraphrasing' and 'reflecting' (Carkhuff, 1969a, 1969b; Egan, 2002; Nelson-Jones, 2003.). These skills developed from analysis of audio recordings of counselling sessions. These researchers were able to delineate many significant features of the counselling process. Rogers (1980, p.138) recalled a sense of excitement as his research team analysed material from recorded interviews.

> Then came my transition to a full time position at Ohio State University, where, with the help of students, I was able at last to scrounge equipment for recording my and my students' interviews. I cannot exaggerate the excitement of our learning as we clustered about the machine that enabled us to listen to ourselves, playing over and over some puzzling point at which the interview clearly went wrong, or those moments in which the client moved significantly forward.

And in a later interview, he added:

> It is true that, because we were recording, we tended to focus on the immediate verbal response. Therefore, we got too wound up in technique; but at the time, it was incredibly exciting to realize that each thing you did or said and – I would add now – each attitude you hold, makes a real difference in the therapy in progress. It was something that we had never done before. It was putting therapy under a microscope, and it was a very good microscope: we learned all kinds of things... I realise, 'Wow, that was a historical step

> that was really fantastic.' At the time, each step seemed entirely natural... But it took me a long time to realise that those seminars were an historical event (Rogers & Russell 2002, pp.128-129).

Seeman (1997, p. 1140), who was involved in the project, claims that this research was "... the beginning of modern psychotherapy research." Once therapeutic skills had been identified in this way and additionally once the effects on the process and outcome of therapy had been charted, the way was open for the adoption of a skills based approach to training in counselling and psychotherapy (Egan, 2002).

3.1.2: The Counselling Skills Movement

As interest in counselling skills development grew apace, Rogers (1980) preferred to stress the need for therapist attitudes and personal qualities, rather than skills. This suspicion of skills has been retained in more recent person-centred practice (Tolan, 2003). Rogers himself moved on to other areas of interest such as encounter groups so that it fell to other researchers (Truax & Carkhuff, 1967) to develop the base for the growth of the 'counselling skills movement' in the late 1960s and early 1970s. These authors developed the Rogerian framework by adding new, more 'action-oriented' skills and more specific definitions of skills connected with, for example, empathy. They also advanced the case for training in counselling skills by showing that unskilled counsellors could do harm to clients. More specific definitions did allow the use of skills to be measured for both teaching and research purposes. Carkhuff (1969a) asserted that competence in counselling skills could be achieved in a training course of 100 hours. This stood in stark contrast to the years of traditional psychotherapy training.

In the UK, there has been a large increase in the number of counselling skills courses from the 1980s onwards. Rushton & Davies (1992), for example, evaluated a 60-hour course to train community-based professionals in the basic skills of counselling families of children with disabilities. They concluded that the course was cost effective and was linked to improved performance by the trainee professionals and linked this to benefits for the subsequent clients of these trainees (Davies & Rushton, 1991).

Ivey (1987) developed a 'micro-skills' training model and similarly Egan (2002) developed the 'skilled helper' model. Some writers, such as Bolger (1985), have argued that the concentration on skills resulted in over-mechanical styles of helping. For the most part, however, many trainers have agreed with Russell & Dexter (1993) that:

> It is no longer plausible to say that the measurement of competent practice is elusive and unquantifiable... if counselling is teachable, it is identifiable and its competent use observable. If it is not, then we must query the validity of counselling courses. (p. 268)

Trainers involved in teaching skills stressed the action-orientated element of helping models (Egan, 2002). Egan's model developed from an integration of Rogerian and cognitive-behavioural theory. The model has an original feature in that it developed some of the stages of the helping process identified by Carkhuff (1969a) into a comprehensive skill model in which specific skills were identified for particular uses at specific stages of therapeutic interventions. In the first edition of the *Skilled Helper,* these stages were identified as: Exploration, Understanding and Action. Egan went on to identify different patterns of skill use for the different stages of the process. A similar sequential use of skills can also be mapped for CBT. Some sequential aspects of CBT skills can be tied to the CBT session structure. For example, agenda setting must be completed near to the start of the therapy session. The sequential nature of CBT skills can be thought of as conceptually similar to the model used by Egan. This allows for identification of where and how specific skills might fit into the overall intervention. Approaches such as the psychodynamic and person-centred models have a particular emphasis on the therapeutic relationship and have often been suspicious of the deliberate use of techniques. Stewart (1978, p.27) comments:

> Apparently a large number of counsellors and psychologists of the humanistic school are theoretically and philosophically opposed to the application of any form of technology to human behaviors.

Kelly (1969, p.55), however, writing from within the humanistic school, asserts that:

> Humanistic psychology needs a technology with which to express its humane interventions.

In describing the use of skills in person-centred counselling, Tolan (2003, p.ix) suggests that:

> It may seem rather anomalous that a book about person-centred therapy, which is so founded on relationships, should have 'skills' in the title. I hope that it will quickly become clear to the reader that this book is not a collection of 'techniques' but one which tries to illustrate the liveliness and immediacy of person-centred practice.

Tolan's book is almost exclusively concerned with achieving empathy, congruence and unconditional positive regard (the Rogerian 'core conditions') in the relationship and does not include material on the intentional use of skills or techniques within that relationship, as would a CB, or other action-orientated, approach.

Milton (2001) has expressed reservations about the 'shallowness' that can arise from the over-emphasis on technique in CBT. A more detailed account of psychodynamic attitudes towards CBT is given in Persons et al (1996) and is presented later in this chapter.

Inskipp (1996) shows how the development of counselling skills teaching has been influential in the development of counselling training in Britain. The British Association for Counselling and Psychotherapy (BACP) has been the principal accrediting body for counselling courses in Britain. In order to achieve course accreditation, training centres must run courses of at least 450 hours training, 200 of which have to be in counselling skills (BACP, 2002). The methods of teaching skills are not prescribed because the accreditation requirements cover courses of different types and orientations. During the 1990s BACP was active in the Lead Body consortium involved in defining and assessing competencies (Aldridge & Rigby, 2001). Defining competency began with defining National Vocational Qualification awards (NVQ) for counselling and more recently has involved defining National Occupational Standards (NOS) for counselling in conjunction with the government-sponsored Skills Council. In the wake of the counselling NVQs, a project to define NVQ awards for psychotherapy was initiated in 1996 but was never implemented. The first report of the NOS project for psychotherapy, which was focused on CBT, reported in August 2007 (Roth & Pilling, 2007). Roth & Pilling's framework for defining these standards is shown in column 7 of Figure 3.2., and will be commented on further in the following section.

3.2: Skills and training for CBT:

Padesky (1996, p.266) notes that:

> Cognitive therapy was one of the first therapies to provide detailed specifications for treatment stages, structure and methods... Clear specification in treatment methods allowed researchers to evaluate how closely therapists adhered to these treatment protocols and whether different elements of these protocols correlated with positive treatment outcome... Treatment outcome... can also be used as a measure of therapist competence... Several studies suggest that therapists obtain better treatment outcome for depression if they adhere closely to the structure of cognitive therapy (Shaw, 1988) and follow the standardised procedures of the therapy (Thase, 1994).

Beck et al (1979) used the protocol that had been developed for the large, multi-site TDCRP trial to develop a competency checklist. This checklist contained 18 different competencies and became the basis for the development of the Cognitive Therapy Scale (CTS; Young & Beck, 1980, 1988). A revised version of the CTS (CTS-R: James et al, 2000) was used in this research and the development of the scale is therefore described in the section on research materials in Chapter 4.

Dobson & Shaw (1993) report the early development of skills-based cognitive training. They identify the key tasks of cognitive therapy and relate them to the need to develop particular skills. The key tasks of cognitive therapy are to help clients to:

- *reappraise* their unhelpful cognitions, and,
- *enact* a new behaviour or set of behaviours based on these reappraisals.

They add (p. 574):

> In order to assist the processes of reappraisal and enactment, cognitive therapists have three principle activities that they need to attend to. These activities, in likely descending order of importance, are: 1) *relationship activities,* 2) *case formulation,* and 3) *techniques.*

This tripartite division fits well with the various skill groupings that will be described in this section, as shown earlier in Figure 3.2.

Dobson & Shaw (1993) regarded the ability to build therapeutic relationships as being as 'relatively immutable' in training. They suggest that the trainee's ability to form such relationships should be assessed as part of the selection process for CB training. The CBT courses in this study make use of interpersonal group exercises as part of the selection process (UWN, Course information 2004). Various aspects of the ability to collaborate –

to listen to and 'run with' the ideas of other group members – can be observed and considered against the requirement for 'collaborative empiricism,' the preferred style for the therapeutic relationship in CBT.

Dobson & Shaw (1993) regarded, subject to the motivation of trainees, techniques as the most teachable of the three sets of attributes. They regard the degree to which one can teach the ability to produce a case formulation as being somewhere between the 'immutability' of relationship building ability and the ready ability to learn techniques. They define a number of trainee characteristics that are likely to enhance the ability to learn the skill of formulating:

1) Commitment to learning cognitive therapy.
2) No strong attachment to another system of psychotherapy.
3) Relative inexperience as a therapist.
4) The ability to tolerate clients' negative emotions.
5) A preference for active, rather than passive, therapeutic styles.
6) 'Psychological mindedness'.

It should be noted that points 2 and 5 above and their link to the nature of trainees' attitudes relate to the research questions posed by the study reported in this thesis. Padesky (1996, p. 270-1) describes her experience as a CBT trainer. She notes that the ability to follow CBT structure must be matched by the ability to form a therapeutic relationship and an understanding of the empirical scientific method. Empirical method must, however, be operationalised with clients to lead them towards guided discovery.

> Therapists who are not willing to participate in a highly interactive therapeutic relationship are poor candidates for Cognitive Therapy training...The ideal cognitive therapist is capable of being highly structured in therapy, comfortable tracking a number of tasks within a session, and yet sensitive to adapting therapy to individual clients to maximise collaboration and positive therapeutic relationships.

Bennett-Levy (2002) notes that role-play exercises are effective in training. For Padesky (1996, p. 281) exercises can take the form of either group demonstrations and/or experiential exercises.

Beginning therapists often learn best from very structured, time-limited, and goal-orientated practice exercises. As cognitive therapists become more skilled, these role-plays can be become very open-ended, with greater therapist choices in goals, clinical methods, and level of client complexity. In this way, experiential exercises become more and more like actual therapy as therapist knowledge and experience increase. In advanced workshops, it is instructive to compare the results of the different therapist choices with the same client situation.

Role-play is a useful low-risk method of trying out skills during the initial phases of the learning of any particular skill set. Skills must be tested in real clinical situations. Course tutors use the CTS or CTS-R to assess CBT practice tapes submitted by trainees. The use of audio and video recordings was incorporated into the early development of CBT practice (Beck et al, 1979; Dryden, 2004) and CBT training and has continued to be standard practice ever since (Dryden, 2004; Padesky, 1996). One limiting factor is that courses mainly allow trainees to choose which tapes to submit. This should, however, limit the danger that a trainee might be assessed on the basis of work with a particularly difficult client (Markowitz, 2001). The interpretation of CTS ratings varies somewhat from course to course. Some courses follow a 'red line' strategy that attributes an overall score at which a trainee is held to have 'passed' the assessment (Strupp et al, 1988). Depending where the red line is set exactly, trainees may have some leeway to do poorly on one or two items if they perform above average in others. Other courses, including the one in the present study, require trainees to reach a prescribed 'pass' level in all items.

There have been two previous studies that have compared pre and post training measures of CTS scores to establish that trainees *do* make significant gains in CBT skill acquisition during training. Williams et al (1991) used the CTS, 1980. Milne et al (1999) used a draft version of the CTS-R with same result. There have been 2 other studies that have examined the effect of therapist competence measured by the CTS on the outcome of therapy (Shaw et al, 1999; Trepka et al, 2004).

Shaw et al (1999) used data collected in the large scale clinical trial, the Treatment of Depression Collaborative Research Project (TDCRP) that compared the treatment effects of cognitive therapy, interpersonal therapy and medication. CBT therapists treated outpatients suffering from major depressive disorder in three different sites using a

format of 20 sessions spread over 16 weeks. The findings offered "... limited support for the relationship between therapist competence as measured by the CTS (1988 version) and reduction in depressive symptomatology" (Shaw et al, 1999, p. 844). Only one of the three outcome measures, the Hamilton Rating Scale for Depression (HRSD-17, Hamilton, 1960), was related to therapist competence, and then only after statistical control for in-take HRSD score, therapist adherence to the protocol and therapist facilitative conditions. Shaw et al (1999) noted that there were difficulties in the TDCRP that contravened their own previous recommendations: especially, for on-going supervision. They also note that one case was removed from the data as an outlier. This case showed very low therapist competence and very poor outcome: had it remained in, a much stronger relationship between competence and outcome would have been demonstrated. The authors discuss the possibility that the CTS does not measure competence fully. Whisman (1993), however, notes that therapists in research trials have already had been assessed for competence to be included in the trial and so are likely to show a narrower range of competence, leading to results likely to be quite conservative in their estimates of the relationships between competence and outcome.

Trepka et al (2004) also researched the relationship between competence and outcome, but in the context of more routine practice situations. A randomly selected CBT session from each of 30 courses of therapy was rated using the CTS, 1988 version, and also the California Psychotherapy Alliance Scale (CALPAS: Marmar & Gaston, 1988). Both therapeutic alliance and therapist competence were related to outcome. In regression analysis, the alliance remained significantly related to outcome when controlling for competence but not vice versa. These relationships with outcome were primarily attributable to therapists rather than to clients. Associations with outcome appeared stronger for those clients who completed therapy than for those who did not. These findings suggested that measurable factors both common to diverse treatment methods and specific to particular methods should be included in efforts to account for therapy outcome.

Separating different CBT skill areas is helpful in that learning skills in different domains may be associated with different phases of the learning cycle for therapists and with different types of teaching and learning strategies (Bennett-Levy, 2006). Bennett-Levy (2006) suggests that there are differences between skills based on declarative knowledge – based on factual learning about how depression affects a client – and skills based on procedural knowledge – for example, clinical judgement. Declarative knowledge skills are learnt in earlier stages of training for neophyte trainees. As training progresses, trainees will be able to try skills and techniques in role play and client settings and will benefit from role play, simulations and case discussions that will enable them to build up procedural skills involving 'when, then' rules. A more advanced type of training and/or on-going supervision may be needed for the development of reflective and interpersonal skills. These skills would focus not so much on establishing therapeutic relationships but on the maintenance and repair of therapeutic relationships when they are tested by more difficult situations (Safran and Muran, 2000). Developing these more complex skills might require that CBT trainees would develop more self-reflectivity. Bennett-Levy and Thwaites (2006) suggest that CBT supervisors should be more prepared to take on this dimension than it traditionally has. There is also a debate within the CBT community over whether CBT trainees should undertake personal therapy, as in psychodynamic therapy. Bennett-Levy and Thwaites (2006) have, however, suggested that a process whereby trainees experience therapy with each other as both therapist and client can perform the same function as personal therapy and can be monitored more carefully within the training course.

Bennett-Levy and Beedie (2007) have studied how CBT trainees experience the development of competence during the period of training. The early period of training is associated with gains in technical competence but much less gain, and in some cases, losses in interpersonal therapy skills. The greater difficulty with learning CBT interpersonal skills may be accounted for by the fact that trainees are having to learn to follow the manual and 'go by the book'. Trainees probably suffer somewhat from divided attention at such times. Similar findings were reported in studies of psychodynamic and interpersonal training studies (Henry et al, 1993a, 1993b; Mackay et al, 2001). In the

study by Bennett-Levy and Beedie (2007) trainee interpersonal skills were starting to improve towards the end of training but we do not know how far this improvement would continue into the post-training situation.

There are some studies that report problems with maintaining training gain unless good quality on-going CBT supervision is available (Dobson and Shaw, 1993; Ashworth et al, 1999). All in all, these studies suggest that there is a need for more interpersonal focus in CBT training and that this should be maintained by supervision into post-training. The development of therapists after training also draws attention to the need for appropriate environments for on-going practice. There may be a tendency for CB therapists to stay within their own professional associations and pre-training areas of practice partly because the development of CBT practice may not be developed or prioritised in other areas. The establishment of national standards is the first step to developing a wider system of support for therapists because such standards can help agencies in all areas to have a system of reference for what might be needed to support the growth of CBT into their areas. Sudak et al (2003) describe CBT competency standards for psychiatric resident doctors in the USA and gives a preliminary list of skills and knowledge areas, an outline of which is shown in Figure 3.2. Roth and Pilling (2007) completed the first draft of national occupation standards for CBT in the UK, also shown earlier in Figure 3.2. At the time of writing (December, 2007), these standards are being drafted and discussed by a working group, of which the author is a member. Compared to the wider field of psychotherapy, the development of identifying, defining, measuring, teaching and promoting skills in CBT has been rapid, though there is still much work to be done. The need for responsive training systems has been evident. Such responsiveness is likely to be needed in order to engage trainees who will come for CBT training having absorbed a different therapy model.

3.3: CBT training with trainees changing models:

It was noted earlier that CBT training is a secondary training for most trainees. The British Association for Behavioural and Cognitive Psychotherapies (BABCP) is made up for 5 main professional groups – Clinical psychologists (30%), Nurses (28%),

Counsellors (20%), Doctors/Psychiatrists (13%) and Social Workers (5%) (Personal communication: BABCP office to author, 2005). All these groups have had a primary professional training during which they are likely to have introductions to, and in some cases more thorough training in, other psychotherapeutic approaches other than CBT.

The earlier description of Dobson & Shaw's (1993) reflections on CBT training noted that a pre-existing strong allegiance to another therapeutic model might constitute a contraindication for CBT training. There have been a small number of authors who have looked into this question further. As this issue lies at the heart of the research questions pursued in this thesis, this chapter will now consider these studies.

Studies that have examined how therapists from other traditions learn CBT include those of Persons et al (1996), Freiheit and Overholser (1997) and Morgenstern et al (2001). Persons is a cognitive therapist and trainer, involved in training psychologists in CBT in her home state of California. Persons trained psychologists who are more likely to be from a psychodynamic background. The study, written jointly with some of her trainees, describes and makes suggestions about how the transition to new learning is made in these situations. Freiheit and Overholser (1997), who are also involved in training psychologists in CBT, cover some of this same ground. Their study involves participants of varied therapeutic backgrounds. It includes pre and post measures of knowledge and skill use – but not, unlike this study, of skill competence. The study by Morgenstern et al (2001) reviews a study of how well counsellors previously trained in '12 step' methods of dealing with addictions can learn the skills of CBT. It does include skill competence measures but they use a measure specifically applied to the addiction field.

3.3.1: The Reservations about CBT held by trainees with a Psychodynamic background:

Persons et al (1996) describe the reaction of trainees from a psychodynamic orientation to CBT training. Persons is identified as a CBT trainer and the other three authors were trainees, originally trained in psychodynamic methods but taught CBT by her. The reservations of psychodynamic trainees about CBT are described. It is not made entirely

clear, however, whether the three trainee authors are expressing their own views or whether they are expressing the views of others as well. Neither is it made clear how they arrived at the set of reservations they describe, for example, whether any data was collected. In the absence of information to the contrary, therefore, it is probably safest to conclude that the three trainee authors are speaking for themselves but also trying to articulate the views of a wider group of psychodynamically orientated trainees and therapists. Three main areas of questions and reservation are described:

1) The therapeutic relationship in CBT,
2) The focus of interventions in CBT, and
3) The depth of change in CBT.

Questions about the therapeutic relationship: For therapists trained in psychodynamic theory and practice, the active, structured and problem-focused nature of CBT is often seen as hindering the development of transference and its interpretation. This is because the transference is expected to be strongest when the therapist is relatively neutral. Psychodynamic theorists regard the active role of the cognitive behavioural therapist as likely to generate even more client reactions. They may also consider the structured nature of CBT sessions inhibits the development of emotional responses necessarily involved in a corrective emotional experience.

> Cognitive behavioural sessions seem to promote corrective intellectual experiences, but not corrective emotional ones. Thus, from the point of view of the psychodynamic therapist, the cognitive-behavioural therapist seems to neutralise or misuse one of the most potent aspects of psychotherapy. The psychodynamic therapist therefore hesitates to use the active interpretations taught by the cognitive behavioural therapist. (Persons et al, 1996. P. 204.)

Consideration of the therapeutic relationship in CBT leads Persons et al (1996, p. 205) to assert that "... psychodynamic therapists, on the whole, still accord a greater therapeutic role to the patient-therapist relationship than do cognitive behavioural therapists."

Questions about focus of therapeutic interventions: Psychodynamic therapy typically involves a process of bringing to conscious awareness highly emotionally charged unconscious material from the patient's past. The therapist helps the client to understand

his or her situation more deeply and clearly and believes that this understanding is essential for healthy change. From this perspective, the cognitive behavioural therapist's route to change may seem to over-focus on solving specific problems, and have "... less emphasis on developing a rich and individualised understanding of the nuances of an individual's psychological situation... and appear to espouse a 'one size fits all' approach... This is exacerbated by the highly structured approach of the cognitive behavioural therapist" (Persons et al, 1996. P.206). Aversion to the perceived over-structured nature of CBT may particularly show itself in the use of skills associated with the start and end phases of sessions:

> The cognitive-behavioural therapist's way of beginning and ending sessions is often particularly objectionable to the psychodynamic therapist. The beginning of a CB session typically includes agenda-setting and discussion of the previous week's homework and may include review of the patient's responses on a symptom inventory, such as the Beck Depression Inventory. By starting the session in this way, the CB therapist seems (to the psychodynamic therapist) to forfeit valuable data about what has been percolating in the patient over the week as well as clues about the patient's current emotional state that the patient may not be able to clearly articulate in the first 2 minutes of the session. At the end of the session, the CB therapist reviews the session and assigns homework for the following week. The procedure is unappealing to the psychodynamically orientated therapist, who has learned that important emotion-laden material often emerges at the end of the session. Thus, from the viewpoint of the psychodynamically trained therapist, CBT focuses prematurely on fixing things without understanding them, and it ignores emotion. (Persons et al, 1996. P. 206)

Reservations about these CBT principles may be associated with difficulty in executing the CBT skills connected with them, such as structuring therapy, agenda setting, pacing, setting homework and eliciting feedback.

Questions about understanding in CBT: CBT has developed by demarcating a series of problems with specific conceptualisations - for example, depression, anxiety and other areas. These may be regarded as general theory models. They are not, however, incompatible with a more idiographic type of conceptualisation that will take principles from general theory and apply them to individual clients. It was only in the second generation of CBT models (Persons, 1989) that this was clarified as a principle of CBT, though it has been argued that the idea of individual conceptualisation was implicit in

Beck's earlier writings (Persons et al, 1996). The apparent lack of emphasis on individual clients may have led therapists from other models to regard CBT as consisting of standardised protocols, so that all patients who meet criteria for a given diagnosis receive the same set of standardised interventions. Learning how to use idiographic conceptualisations is, however, now regarded as a standard part of cognitive therapy training (Padesky, 1996). As a study of the use of protocols (Payne & Blanchard, 1995) illustrates, cognitive behavioural therapists are beginning to incorporate the individual formulation process into their standardised protocols. Persons et al (1996, p. 207) summarise the situation as follows:

> It is also accurate to say that cognitive behavioural therapists place less emphasis on understanding and more on change than psychodynamic therapists... Cognitive behavioural therapists are willing to consider changing something even if they do not understand it very well.

Psychodynamic therapists have identified emotional content as an area in which the highly structured format of CBT sessions is sometimes seen as promoting emotional avoidance. A more accurate critique could point to the fact that cognitive behavioural therapists may indeed encourage clients to over-ride emotional reactions at times and that some have postulated that this capacity to use such emotional management in appropriate ways is one the essential elements of 'emotional intelligence' (Epstein, 1998).

Questions about depth of change in CBT: Previous discussion linked the psychodynamic concept of 'working through' with working at the level of 'deep change'. By contrast, CBT may seem like it could promote only shallow change:

> To the psychodynamic clinician, the symptom-focused, problem-orientated nature of CBT makes it appear 'Band-Aid' like, intent on removing symptoms while apparently ignoring their underlying mechanisms – as if the cognitive behavioural therapist were attempting to cool a feverish patient without addressing the underlying pathology that causes the fever (Persons et al, 1996, P.209).

In response to this criticism, Persons et al (1996, p. 209) suggest that although "Cognitive behavioural therapists do tend to focus on overt problems; the work on overt problems is guided by a hypothesis about the underlying mechanisms." Here they are referring to the principle of 'formulation' based on CBT concepts.

The CB therapist may therefore seem to psychodynamic trainees to view overt symptom change as the goal of treatment and to be unconcerned about underlying change but the cognitive behavioural therapist himself would rather hypothesise that direct work on overt problems will produce underlying change. Persons et al (1996) summarise the position thus:

> It is certainly accurate to say that the cognitive behavioural therapist is first focused on symptom removal and in this respect often operates quite differently from psychodynamic therapists. (p. 210)

Having reviewed these points, however, they reach the conclusion that CBT is more similar to psychodynamic models than trainees may suppose. This is not to say that there are no significant differences. The authors suggest that such differences should be clarified and used as stimuli for further learning.

> We believe that a clear awareness of differences can facilitate learning and teaching. (Persons et al, 1996. p.203).

They suggest that psychodynamic therapists' reluctance to experiment with CBT will diminish if they are more aware of points of convergence. Some differences between the models could in principle be resolved empirically. For example, the questions of whether the "top-down" approach used by the cognitive behavioural therapist or the "bottom-up" approach used by the psychodynamic therapist provides greater protection against relapse or whether each is appropriate to certain groups of patients but not others are empirical ones. Other differences between the models seem to have more to do with matters of values rather than matters of fact (Bolter et al, 1990: Messer & Warren, 1998).

Persons et al (1996, p.211) therefore sum up their findings and recommendations:

> Like patients, trainees arrive in the classroom with value-laden models of psychopathology and psychotherapy that are not fully conscious or articulated and that they are not eager or able to summarily relinquish. The teacher's job is to help trainees become aware of their pre-existing penchants and predispositions, examine them, and acquire new information that allows them to make whatever adjustments they might wish to make to their own working models... Thus, we argue that an important strategy for

> overcoming obstacles to teaching and learning is to make the obstacles explicit and to promote flexible, thoughtful examination of them.

And further (p. 203):

> Our experience is that willingness to try a new idea or new intervention is a key step in learning a new model. This step is an important one because it probably leads to some value shifts as the therapist begins a process of critically examining his or her values by testing them in the crucible of therapy. Our experience is that psychodynamically trained therapists who are aware of and can articulate their reservations about the cognitive behavioural approach to the therapeutic relationship are able to experiment more fully with CBT.

This study is a helpful guide to the kind of theoretical objections and reservations that therapists with a background in another theoretical model might hold whilst undertaking training in CBT. Although the focus is on the way psychodynamic model may shape views of CBT, trainees with a humanistic view of therapy may hold similar objections. The weakness of Persons et al's (1996) study is, however, that it does not make it clear how data were obtained. Additionally, it does not present any kind of follow up data concerning the extent to which these trainees actually went on to practice CBT or on their competence to do so. The study by Freiheit & Overholser (1997), described below, addressed some of these points.

3.3.2: Trainees from multiple orientations: Freiheit & Overholser (1997)

Freiheit and Overholser (1997) undertook a study of post graduates training in clinical psychology and CBT within an American university. The trainees had varied prior experience in a variety of different theoretical positions. This was a typical training situation and one that the authors consider will have to be taken into account more frequently in the future.

> A central issue not yet addressed by the current cognitive behavioural training literature is how to effectively teach cognitive behavioural techniques to individuals from other therapeutic orientations (Freiheit & Overholser, 1997, p.79).

Such trainees will have varied attitudes towards CBT and these may affect how they learn another approach to therapy. These attitudes may in turn affect their capacity to achieve competence in CBT.

Freiheit & Overholser (1997) followed 6 cohorts of CBT trainees through six successive one yearlong praticums. The cohorts were small – between 6 to 8 trainees, resulting in 40 participants in the study as a whole. All trainees were Caucasian and 30 of the 40 were female. The mean age of the trainees was 28.28 years. Trainees had to choose training in two models from the client-centred, psychodynamic and CBT approaches. If they chose the CBT option, they ere grounded in general CBT practice in Semester 1 and undertook training in Beck's cognitive therapy in Semester 2. They also undertook supervised clinical practice during the period of training. They had all had some previous experience of clinical practice – a mean number of 68. 2 hours in such practice.

The study set out the test the following hypothesis:

> It is expected that trainees who enter the course with a cognitive behavioural orientation will gain more knowledge, have more positive attitudes, and report using cognitive-behavioural skills more often than trainees who are not cognitive behavioural. (Freiheit & Overholser, 1997, p.80)

The authors devised a combined measure and questionnaire - Behaviour Therapy Survey (BTS). The BTS has 3 Sections:

- Knowledge: 20 multiple choice questions about CBT theory and practice.
- Attitudes: 25 Lickert-type statements on attitudes to general and specific therapy principles.
- Behaviour related to CBT: Estimates of how many hours of CBT practice and the extent of use of techniques in everyday practice.

The BTS was used as a pre and post-CBT training measure. Analysing how students' understanding of CBT developed over the period of the training intervention, the authors identified the following trends in their data:

- Negative evaluations of CBT were strongest amongst trainees with a psychodynamic orientation at pre-test but these negative evaluations of CBT decreased significantly at post-test.

- Trainees who began the training with positive evaluations of CBT reported a non-significant increase in positive evaluation of CBT at the end of training.

- The pre-test positive evaluations of CBT from trainees with behavioural, humanistic & psychodynamic orientations stayed the same at post-test.

After training, there appeared to be 3 groups with significantly differently attitudes to CBT: pro-CBT, anti-CBT and undecided. These 3 groups showed no significant differences with regard to the number of hours of CBT practice that they were undertaking in the period after the course. No differences between the 3 groups were observed with regard to either cognitive behavioural knowledge or the frequency of use of behavioural, cognitive techniques at pre and post-test. The main differences echo Persons et al (1996) – emphasising the initially greater negative evaluation of CBT, initially less positive evaluation of CBT amongst trainees with a strong previous allegiance to the psychodynamic orientation. These differences were reduced by training so that Freiheit & Overholser (1997, pp. 83-4) summarise their results:

> The results suggest that participating in a course about CBT significantly decreases initial negative biases toward CBT. Moreover, regardless of initial therapeutic orientation, the students gained similar amounts of knowledge and reported using CB techniques with similar frequency over the course of the CB practicum... Although trainees who initially entered the practicum without a CB orientation had significantly more negative evaluations and fewer positive evaluations of CBT than trainees from a CB orientation, in general trainees attitudes toward CBT improved. (pp. 83-4)

However, an increasingly positive attitude towards CBT did not indicate any great reduction in belief in previous orientation:

> While trainees held their ideas about other orientations, their attitude about CBT improved. (Freiheit & Overholser, 1997, p.85)

These findings are compatible with the concept of cognitive dissonance (Festinger, 1957) and might suggest that a change of mind takes place over several cycles - holding two separate ideas may be a way-marker of a longer-term change process. Alternatively, we cannot rule out the possibility that trainees may revert to previous theories and practices after the immediate impetus of training. Additionally, these particular trainees were

relative newcomers and more lasting changes in orientation might have a much longer gestation period than was available in this study.

Freiheit & Overholser (1997, p. 85) note the following limitation related to the lack of skill use assessment measures:

> Moreover, the proficiency of using cognitive behavioural techniques as trainees was not assessed. Because students had different supervisors, the utility of competency-based scores would have been questionable. Future research may want to address whether trainees from other orientations become as competent at using cognitive behavioural techniques as trainees with a cognitive behavioural bias." (p.85)

They finally conclude that:

> Remaining open to research and new techniques in psychotherapy may lead to replacing older, less effective techniques with new, more effective techniques. The practising clinician has a responsibility to remain current with psychotherapy research, (APA, 1992), and to incorporate new effective techniques into their practice... In essence, graduate students and practising clinicians may need to remain open to new treatment modalities and continue their education in therapeutic techniques so that their clinical skills will continue to improve. (p. 85)

One deficit of this study was that it did not follow up trainees after training. Another was that it lacked any assessment of how well the trainees learnt CBT skills. This deficit is partly addressed in the following study of trainees from a substance background by Morgenstern et al (2001).

3.3.3: Trainees from a substance abuse background: A CBT Training Study by Morgenstern et al (2001)

The authors analyse a CBT training project in New Jersey, USA during which a group of 29 counsellor trainees, who had a strong pre-existing therapeutic approach (the '12 step approach' (Denning et al, 2004) with attitudes dissimilar to CBT) entered training in therapy for substance abuse. 20 of the subjects were trained in manual-guided CBT methods for substance abuse and 9 entered non-CBT based training.

The trainees had considerable experience in the field but were without any previous training in higher-level therapeutic skills and/or CBT. The training itself involved 35

hours of intensive didactic instruction over two weeks followed by on-going supervision groups. The authors had three research aims: firstly, to examine the trainees' experiences of training, secondly, to explore the relationship between trainees' beliefs about addiction and therapy:

> Specifically we assessed whether counsellors allegiances to the 12 step approach posed an obstacle to learning CBT and whether training served to modify counsellors' beliefs in 12 step and social learning theory models (Morgenstern et al, 2001, p. 84).

A third aim was, to evaluate the counsellors' ability to deliver CBT following training.

Relationship between the Counsellor/Trainees' Beliefs and adaptation to CBT training

In order to establish changes undertaken by the counsellor trainees during and after training, the authors used the following pre and post training measures of therapeutic attitude and skills:

1) Understanding of Alcoholism Scale (UAS) 50 items arranged in 2 subscales: a) Disease model subscale. b) Psychosocial model subscale.
2) Treatment Processes Questionnaire (TPQ) with 35 items, including items on the Disease Model (10 items), the Psychosocial model subscale (17 items) and 8 other items.
3) Match video tape rating scale (MTRS).

Repeated measures were taken and ANOVA analysis was used to determine if counsellors in the CBT training group reported significant increases in social learning belief and decreases in disease model belief following training. The results showed that the group put into the CBT training condition reported a decreased level of adherence to disease model beliefs, whilst these beliefs increased in the non-CBT substance abuse training condition. Generally the counsellors in the CBT training group saw CBT as not conflicting with previously held beliefs about substance abuse counselling when the training was part of a wider programme. When the CBT training was a 'stand-alone', however, they saw it as a moderate to severe threat to previous beliefs.

From the respondents' qualitative responses, the authors concluded that the counsellors had been able to accept CBT training because they held disease model beliefs prior to training in a way that showed "little evidence of dogmatism and closed-mindedness" (P. 134). Respondents also "acknowledged the limitations of current treatments and were actively searching for new skills that could improve client outcomes" (p.134).

The MTRS had been devised for a previous CBT trial with substance abuse problems, Project MATCH in 1997. The post training MTRS scores did show significant gains in CB skills in the trainees who had undertaken the CBT for substance abuse training condition, 90% of whom were deemed to have to have attained at least adequate levels of CBT skilfulness. The MTRS measure, although it does contain items similar to the Cognitive Therapy Scale, also contained a number of substance abuse specific skills. It cannot therefore be directly compared to results of skill assessment using the CTS. Neither do the authors present any analysis of different types and levels and pre-training beliefs. They seem to assume a degree of uniformity of beliefs amongst these particular trainees.

Further major limitations to the study were that only a very limited range of CBT coping skills were taught (Kadden et al, 1992) and that no attempts were made to assess client outcomes.

3.3.4: Overview of studies of CBT training with trainees with non-CBT orientations

Overall, these studies suggest that problems associated with training people from a non-CBT therapeutic orientation into the concepts and skills of CBT are not insuperable. All three studies describe trainees who are at a comparatively early stage in their careers or had not received substantial prior therapy training. It may be remembered that Dobson & Shaw (1993) suggested that such trainees may more easily change models. Even so there is a minority of trainees for whom such a change of track in problematic. The studies have given some qualitative indication of who these trainees are and what attitudes they held but these indications have not been backed up by fuller quantitative data. The fact that none of the studies described above have been able to incorporate CTS style skill

assessment also means that they have not been able to describe whether any of these difficulties are mirrored in the acquisition of practice skills. The study in this thesis was specifically designed to throw further light on the question of how training affects skill acquisition, especially for trainees beginning from a different model outlook...

The studies do not describe any of the mechanisms and processes of attitude change in therapy training. The current study collected qualitative data from interviews with trainees and these interviews contain reflections on the nature of belief change during training. Morgenstern et al (2001), however, did note that differences in the way new pieces of information are taken on might be influenced by how trainees viewed the purpose of that information in relation to previously held beliefs. The context of CBT training within the trainees' overall training programme might influence trainees' perception of this point, for example, whether the CBT training was a 'stand-alone' or 'subset' element. Atherton (1999) has also expresses a similar idea in his differentiation between 'additive' (when new knowledge is intended to add to existing knowledge) and 'supplantive' (where new knowledge is intended to replace existing knowledge) training in his description of training social care workers in new interventions. He suggests that 'supplantive' training is seen as much more threatening to current practice and is therefore subject to more resistance from trainees. For adherents of other therapy models, training in CBT would be more akin to supplantive training and might require some significant attitude change, perhaps using a prime method change in CBT and in the educational field: the Socratic dialogue.

The fact that current trainees in CBT come for training with backgrounds in other primary professional training means that they are mature adults and raises the relevance of adult education theory to their situation. This theory, which emphasises self-directed and experiential learning, has been influential in approaches to counselling education (Johns, 1998). Such student centred learning stresses the value of trainees defining their own learning targets and enjoying strong participation in course and assessment processes. It has however, been increasingly realised that adult education covers a wide range of activities: for example, from a non-certificated evening class to certificated

professional training, such as the courses described above and in this study. Merriam (1993, 2001) argues therefore that the way adult education theory is implemented varies considerably in different contexts. Where there are centralised validating processes and professional scrutiny of training, the democratic and liberal processes of andragogy cannot be realised in the same way. Knowles, the best known advocate of the andragogy concept himself acknowledged this fact by amending his view that andragogy and pedagogy were mutually exclusive phenomena to describing them as being on a continuum (Knowles, 1984).

Cassidy (2004) has reviewed the place of CBT training for psychiatric residents in Canada. He surveyed a large group of residents and found that they held a highly andragogic attitude towards CBT training when viewed as part of their continuing professional development. This saw CBT as not only a useful set of additional psychiatric intervention techniques but also as of personal value to trainees. Whilst it can be seen as a suitable model of education for psychiatric residents, we might be cautious of applying the same perspective in other likely training contexts for CBT. Whilst resident psychiatrists may take it as useful 'additive' training, other professionals with other statuses may regard the training as having implications for their professional future and correctly see the process as leading to more controlled entry into a professional status. From this perspective, they might not expect, or indeed welcome, an overly democratic training experience. Such expectations are only likely to be exacerbated by the policy imperatives that favour the growth of CBT services (Roth & Pilling, 2007). In practice, however, CBT training does try to mirror some of the collaborative nature of CBT itself by encouraging self-direction and reflective practice (Bennett-Levy, 2002) – for example, the way reflexivity may be encouraged by tutors and other course members using guided discovery in the contexts of skill and practice development. The process of assessment, however, is usually expert-centred because of the professional accreditation that is linked with it.

3.4: Conclusion to Chapter 3

After many years when training for psychological therapy did not focus on skills, the counselling and psychotherapy training fields have now become increasingly aware of the need for quality training in therapeutic skills. Although skills are complex and many-layered, progress has been made in identifying and measuring therapy skills and relating them to outcome. There is a resonance between the principles of CBT and skill development. This resonance has also allowed CBT to advance in the context of evidence-based practice. Much has been learnt about CBT skills and CBT skills training, though much still remains to be learnt. Current developments in the field are likely to result in more effective models for so doing. As the need for training in empirically supported therapies goes up the policy agenda, so does the likelihood that therapists with other types of training will wish to undertake CBT training as either additive or supplantive to their current practice. Studies on training therapists with other model preferences are not only useful in themselves but also highlight certain principles that can strengthen models of training and skill acquisition.

The review of current studies has, however, shown a gap in current knowledge in that none have focused on skill acquisition in the situation where trainees may be changing model. This study therefore took skill acquisition in the context of model change is its main focus. It examined the therapeutic attitudes of succeeding cohorts and the growth of their competence in CBT. The study operationalised these aims with the following four research questions:

A: What attitudes do trainees entering a CBT training course hold towards CBT practice principles and how do these attitudes develop during training and in the year following the end of training?

B: With what level of pre-existing competence in performing skills associated with CBT practice do trainees enter CBT training and how do these CBT skills develop during training?

C: What kind of association and influence do the attitudes towards CBT principles held before and during training have in the development of competence in the skills associated with CBT practice?

D: What characteristics of CBT training and development do CBT trainees most often report as being most likely to lead to the resolution of difficulties in learning CBT during training?

The following Chapter, 4, describes the methods devised to research these questions. Chapters 5 and 6 present quantitative and qualitative results respectively and Chapter 7 concludes the study by discussing its overall results and reflecting on the educational and policy implications for the practice of CBT training.

CHAPTER 4: Methodology

This chapter will begin by describing and explaining the research design used in this study. Having described the strategy followed by the research, it will then describe the detailed and sequential steps taken to:

- Justify the selection of research design related to the research questions and hypotheses of this study.
- Identify and recruit participants,
- Design and develop research materials,
- Develop the procedures followed to collect and analyse relevant data.

4.1. Design

The research questions posed in this study required that a wide view be taken of various aspects of trainee development and performance over a time span of up to three years. The project was designed therefore as a longitudinal study that collected data from three successive annual cohorts of a University-based training course in cognitive behavioural therapy. The focus of interest was in how different sub-groups within the trainee cohorts responded to the stimulus of the training course. Although the study had some similarity to an outcome study, it was naturalistic and did not use control groups and/or random allocation of participants and was not therefore an experimental design. Data collection activities for the study consisted of gathering data from the same participants as they reached different stages of the training process: pre-training, post-training and at one year follow-up. Data collection techniques were by survey questionnaire and by interview. The questionnaire was administered at pre-training, post-training and one-year follow-up. A principal element of the questionnaire focused on trainee attitudes towards the therapeutic principles being taught in the training, particularly on the degree to which trainees regarded these principles as compelling therapeutic principles: that is, principles that were valid over a wide range of therapeutic situations. The questions relating to these principles were asked in exactly the same form at each of the stages of the training process, described above. They therefore constituted 'repeated measures' and allowed for

analysis of the trainees' attitudes over the period of the training process. Other questions in the questionnaire determined various characteristics of trainees: for example, age, gender, employment and pre-existing therapeutic orientation. This allowed for subsequent analysis to explore whether subgroups of trainees based on these categories had significantly different responses to training: in particular, did trainees with different pre-existing therapeutic orientations react differently to the training: especially with regard to acquiring competent use of the therapeutic skills taught in the training for cognitive behavioural therapy.

The interview schedule was semi-structured and consisted of open questions and prompts, designed to encourage respondents to give more open and reflective responses than were possible in a questionnaire. This resulted in valuable qualitative data that often focused on similar areas to the questionnaire responses. This allowed for a degree of data triangulation. Benefits that can follow on from such triangulation include the ability to check whether respondents give the same information to differently phrased questions on the same subject: for example, both questionnaire and interview asked about first model preference and about what respondents had found helpful and conversely, difficult, about CBT training. Additionally, whereas questionnaires generally facilitate a larger number of respondents, interviews are often more successful in getting at more subtle aspects of the data. About model preference, for example, respondents could have a preference but not feel able to implement methods associated with such a preference and therefore not able to label themselves with that preference when interacting with clients or other therapists.

The assessment of trainees' competence involved appraisal of CBT practice tapes by using a standardised competency measurement inventory.

4.2. Participants

The survey was conducted with all the participants in three successive annual cohorts of a training course in cognitive behavioural therapy. There were 59 trainees recruited into

three successive cohorts of the CBT training course. Response rates are shown in Table 4.1.

Membership of the cohort groups of the training course was regarded as the sole inclusion criterion for the study. Failure to complete the course was regarded as limiting the inclusion of data from the trainees concerned - e.g., results could be compared up to the time when the person left the course but results for the person could not be retained in comparisons of later outcomes.

4.2.1: Attrition of questionnaire respondents

In longitudinal research, decisions invariably have to be made about how to handle data on participants who leave the study before it finishes (Robson, 2002). People who drop out of studies may be over-representative of some classes of participant (Howitt & Cramer, 2000): for example, trainees with less secure practical arrangements for their training: such as arrangements concerning the payment of training fees and granting of study leave. Excluding such trainees from the data set has the potential to introduce bias into the study. Such exclusions could be particularly difficult in a longitudinal study because all previous responses may have to be left out of the analysis. This can threaten the sample size and the internal and external validity of any findings. In this study, the drop out rate during training did not turn out to be a great problem: only 2 trainees left the training programme and these both occurred within the first few weeks of training. These trainees were not replaced. They both gave the reasons for leaving as 'personal' and indicated that they wished to return to study in the following year – though neither did. Although they both did respond to the initial questionnaire, it was decided to exclude these responses from the study altogether because neither trainee reached the point in training when CB skills assessments- that were at the heart of the research questions on CB competencies - were made. Two further trainees chose not to respond to any requests for information and they also were eliminated from the study. Having responded to requests for information once, most trainees continued to respond to further requests, although a small number, 4 of 55 available at post-training and 3 of 51 available at one-year follow-up administration of the questionnaire, did not. Participants in the

questionnaire survey gave data under an anonymous survey number. The questionnaire contained a question asking respondents if they were willing to participate in a semi-structured interview after completing the course. 30 trainees had completed all their studies by the time of the interviews and were thus invited to interview. 24 agreed to participate - see Table 4.1. All participants who did not respond to any particular request for data were followed up once only with a further request. The data concerning trainees who failed to respond to some further requests was kept in the study and was used in the analysis when data relevant to the stages in which the respondents had given information was considered.

Table 4.1: Response Rates for Questionnaire and Interview Data Collection in the Study

	Time 1 (Pre-course)	Time 2 (End course)	Time 3 (Follow-up questionnaire)	Time 4 (Follow-up interview)
Available sample	59	55	51	30
Respondents	57 (55 admitted to study).	51	48	24
Response rate	96.6% (93.2%)	92.7%	91.9%	80%

It was not practical to use the same time sequence as shown in Table 4.1 for skill assessment because the prospect of participants submitting tapes once they had the course were uncertain. Data on skill performance were therefore collected just immediately prior to the commence of training (Time A: pre-training), at the half way point in training (Time B: mid-training) and at the end of training (Time C: end of training).At Time A data on the pre-training skill performances of 41 of the 55 trainees admitted to the study and who submitted a pre-training tape was measured using a standardised CBT competence measure – see Section 4.3.2. Skill performances on these 41 trainees was also measured at Time B, mid-training, and Time C, end of training assessment, along with skill performances of 14 trainees who had not submitted pre-training tapes but who were assessed at mid-training and end of training.

4.3. Materials

The research materials used for the study were:

1. The Cognitive Behaviour Therapy Training Questionnaire (CBTTQ).

2. The Cognitive Therapy Scale - Revised (CTS-R).

3. A semi-structured interview schedule.

4.3.1. The Cognitive Behaviour Therapy Training Questionnaire (CBTTQ)

The questionnaire was developed using the principles of questionnaire and scale development suggested by Oppenheim (2000). At the core of the questionnaire was a set of attitude statements, grouped together as an inventory: the Cognitive Behavioural Principles Inventory (CBPI) – based on the principles formulated by Beck & Emery (1985) and Beck (1995) and described in Chapter 2. These principles were transcribed into attitude statements, generally keeping close to the format used in Beck & Emery (1985) and Beck (1995). Each principle was, however, operationalised by using up to 5 different ways of stating each of the ten principles. These statements were then piloted on trainees from previous cohorts and in other similar programmes of study.. It was possible to select out the 10 principle statements that elicited the fewest queries from responders and gave the most consistent responses. The final form of questionnaire was achieved by adding 22 further questions concerning other aspects of the students' characteristics and situations that were relevant to the research questions. A further round of piloting of the whole questionnaire was conducted during which various amendments to questions were made. The final versions of 32 questions were organised into the questionnaire as follows[6]:

Section A.	Background information. (7 questions)
	Gender, age, present job, time in post, previous job,
	Duration and type of education, professional qualifications.

[6] Full copy of all versions of the questionnaire are in Appendix 1.

Section B	Employers attitudes towards training in CBT (5 questions) Practical support (Fees, study leave, study allowances, CBT supervision, Other.) Encouragement (CBT priority, general support) CBT qualification seen an advantage. Future in present type of post.
Section C	Attitude to Therapeutic Principles (13 questions) Previous model preferences & strength of preference. (3 questions). Cognitive Behavioural Principles Inventory. (CBPI) (10 questions)
Section D	Experiences of Learning CBT (3 questions) Difficult & beneficial aspects; expectations of how practice will change.
Section E	Research Process Questions (4 questions) Access to summary results; perceptions of questionnaire; perceptions of research topic (any suggestions); permission to be interviewed.

The questionnaire had to be varied somewhat for each stage of its administration: for example, the question 'What do you expect to be the most difficult aspects of learning CBT?' (Question D1 in the Pre-course version) had to become 'What did you find to be the most difficult aspects of learning CBT?' in the post-course and follow-up versions. Some questions – for example, on the trainee's preferred therapy model at the pre-training stage – were eliminated from the later versions. The questionnaire therefore had small variations in question format for its pre-training, post-training and follow-up versions. The CBTTQ questionnaire in its two versions (pre-training, and, post-training & follow-up) is in Appendix 1.

4.3.1.1: The Cognitive Behavioural Principles Inventory (CBPI)

The CBPI constituted a major section of the CBTTQ and asked trainees to respond to 10 attitude statements based on the 10 principles of CBT described in Chapter 2.

Respondents were asked to indicate the level of agreement held with the statements. Responses were requested to a Likert scale, where 4 = strong agreement, 3 = agreement, 2= disagreement, and, 1 = strong disagreement. These statements remained the same throughout the study and acted as repeated measures of responses to the attitude statements. When the Inventory was piloted some respondents wrote comments indicating that their response might depend on the situation they were dealing with. The following instruction was therefore: "It is sometimes difficult to generalise about these principles. Try to think about how they might apply to a typical client of your practice."

4.3.2. The Cognitive Therapy Scale - Revised (CTS-R)[7]

Beck et al (1979) listed a series of competencies associated with cognitive therapy. Each competency item had various defined levels of competence. The derivation of these competencies is not discussed. They were revised into the Cognitive Therapy Scale (CTS: Young & Beck, 1980) and used extensively in subsequent trials of cognitive therapy. A rating manual (Young & Beck, 1980) accompanied the scale. The competency items were condensed and reduced into 11 items. The CTS scale has been widely used and has shown good reliability and validity (Vallis et al, 1986; Beckham & Watkins, 1989). Some further adjustments were made in 1988 (Young & Beck, CTS, 1988). Researchers and trainers at University of Newcastle reported some difficulties in obtaining inter-rater reliability amongst staff on their training course (James et al, 2000; Milne et al, 2001). They undertook a project to improve inter-rater reliability by offering staff further training in using the Scale. This project resulted in a revised scale with 12 items: the Cognitive Therapy Scale Revised (CTS-R, 2000). Reichelt et al (2003) reported improved reliability for this revision. These developments represent active attempts to improve competence measurement but give some problems in reporting as all three versions are in current use. In Britain, the CTS-R is a widely used scale on training courses and was used to analyse the data in this study. The different versions of the scale are shown in Figure 3.3 and all future references in this thesis to the use of the scale will be labelled to indicate which version was used. CBT competency measures, such as the CTS-R, are often used alongside therapy manuals in both training and research trials.

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[7] A copy of the CTS-R is in Appendix 2

Figure 4.1.The Development of the Cognitive Therapy Scale

1979 Checklist (Beck et al,1979)	CTS (Young & Beck, 1980)	CTS (Young & Beck,1988)	CTS-R (Milne et al, 2001)
2) Establishing agenda	1) Agenda setting	1) AGENDA SETTING	**1) Agenda**
3) Elicited Reactions to Session and Therapist	2) Feedback	2) FEEDBACK	**2) Feedback**
	3) Understanding	3) UNDERSTANDING	
18) Rapport	4) Interpersonal effectiveness	4) INTERPERSONAL EFFECTIVENESS	**5) Interpersonal effectiveness**
1) Collaboration and Mutual Understanding	5) Collaboration	5) COLLABORATION	**3. Collaboration**
4) Structured Therapy Time Efficiently	6) Pacing.	6) PACING	**4. Pacing**
6) Questioning.	7) Guided Discovery	7) GUIDED DISCOVERY	**8) Guided Discovery**
10) Elicit NATS, *11) Test NATS*	8) Focus on Cognition	8) FOCUS ON COGNITION	**7) Focus key cognitions**
		9) CONCEPTUALISATION	**9) Conceptual integration**
5) Focused on Appropriate problem.	9) Strategy for change	10) STRATEGY FOR CHANGE	
12) Identify Assumptions	10) Application CB techniques	11) COGNITIVE TECHNIQUES	**10) Cognitive techniques**
9) CB techniques	10) Application CB techniques	12) BEHAVIOURAL TECHNIQUE	**11) Behavioural techniques**
8) Assigned homework	11) Homework	13) HOMEWORK	**12) Homework**
7) Summaries	Overall assessment	Overall assessment	
Genuineness.	Specific problems	Specific problems	**6) Eliciting emotion**
Warmth			
Accurate Empathy			
Professional Manner			

Trainees were required to submit examples of CBT practice with real clients, authenticated as such by their supervisors, on audiotape for course assessment purposes: so that their ability to successfully practice CBT methods could be assessed by the trainers. Trainees have to reach a defined level of competence to pass the course and to be awarded the qualification, Diploma/MA in Counselling (Cognitive-behavioural). Immediately before the start of the course, they were asked to supply an audiotape of a CBT session with a real client. This was used to give a pre-training baseline measure of CB competence. The tapes were assessed using the Cognitive Therapy Scale Revised (CTS-R; Milne et al, 2001) an instrument for measuring adherence to and competence in following the structure and using the techniques of cognitive behaviour therapy. The CTS-R is a revised version of the Cognitive Therapy Scale (Young & Beck, 1980) and assesses the following aspects of the therapy session:

General therapy items:

1) Agenda-setting and adherence.
2) Feedback.
3) Collaboration
4) Pacing & efficient use of time and efficient use of time.
5) Interpersonal effectiveness.

Specific CBT items:

6) Eliciting appropriate emotional expression.
7) Eliciting key cognitions.
8) Eliciting behaviours.
9) Guided Discovery.
10) Conceptual integration (Formulation).
11) Application of change methods.
12) Setting homework.

Milne et al (2001) describe the rationale for the revision of the original CTS as being based on two main factors. Firstly, some confusion has arisen over the fact that the original CTS itself was revised in 1988 (Young & Beck, 1988), partly to allow it to take account of some developments in CBT. The second version has not, however, been subjected to the same validity and reliability testing that the first one was and this has resulted in both versions being in use at the same time. Secondly, Milne et al (2001) reported low levels of inter-rater reliability for the CTS and this was commonly considered to result from the fact that there was significant overlap in items relating to the therapeutic relationship. Milne et al (2001) suggest that the CTS has not kept pace with theoretical and practice developments in CBT. They believe that the original version of the CTS was too focused on acquiring techniques and not focused enough on the therapist's ability to facilitate experiential change for the client. They suggest that experiential change is essential for therapeutic improvement and they follow the model of experiential learning proposed by Kolb (1984). They produced a revised version of the scale, which retained 10 items of the original CTS and added 4 new items focused on experiential change to the original items: Interpersonal effectiveness; Facilitation of emotional and experiential expression; Facilitation of experiencing and General facilitation of movement round the experiential cycle to take more account of the need to facilitate experiential learning for the client. Eventually, however, they collapsed 3 of the 4 new categories into one, producing the 12-item scale shown above. They also suggest a new scoring system based on the levels suggested by Dreyfus & Dreyfus (1986):

Level 0:	Incompetence.
Level 1:	Novice.
Level 2:	Advanced beginner.
Level 3:	COMPETENT.
Level 4:	Proficient.
Level 5:	Expert.

Criteria for these levels in relation to each skill are defined in the CTS-R Manual (James et al, 2000). Level 3 is regarded as the level of competence to be achieved by the end of training. In this study, therefore level 3 and above were regarded as having achieved

competence and level 2 and below as not having competence. The data was recorded to allow calculation of mean competence rates for each skill.

Blackburn et al (2001) investigated the psychometric properties of the CTS-R. They analysed its use in assessing 102 videotapes of therapy provided by 21 mental health trainee CB therapists. Four experienced raters assessed the tapes using the CTS-R. The CTS-R showed strong internal reliability with Cronbach alphas ranging from 0.92 to 0.97. The authors assessed inter-rater reliability by calculating intra-class correlations (ICC) for all scale items. These ranged from 0.34 to 0.86, with an average of 0.63. These ICCs were slightly superior to those calculated by Vallis et al (1986) for the original CTS. Whilst acknowledged that further work was needed on validity, the authors maintained that, "The *face validity* of the CTS-R is good, as the expert raters all agreed that they found the scale easier and more meaningful to rate than the original CTS. All found it difficult to go back to using the CTS in their daily work, after rating 51 tapes each on the CTS-R" (Blackburn et al, 2001, p. 440). Work has continued on developing CTS-R assessment and the authors and their associates have regularly reported back to annual conference of BABCP. One helpful development has been the emergence of specialised training in rating CBT tapes. Reichelt et al (2003) have reported that such training does result in significantly improved inter-rater reliability amongst groups of staff members who have overtaken it. For these reasons, it was considered appropriate to use the CTS-R for assessing tapes in this study.

4.3.3: How the Principles of CBT are linked to CBT practice skills

Beck (1991b) has argued that there is an unusually close fit between CBT theory and practice and having examined the principles closely in Chapter 2, we are now in a position to estimate the degree of fit between them and the main defined skills of CBT. The position is laid out in Table 4.2, where the 10 principles are put alongside the CBT skills nominated by the Cognitive Therapy Scale - Revised (CTS-R: James et al.

Table 4.2: The Congruence between the Principles of CBT and CTS-R Items.

Cognitive Therapy Revised Scale Items	Beck & Emery (1985) Principles
1. Agenda Setting	***CBT is structured and directional***
2. Facilitating emotional expression	***A sound therapeutic relationship is required for effective CBT***
3. Interpersonal effectiveness	***A sound therapeutic relationship is required for effective CBT***
4. Collaboration	***CB Therapy is a collaborative effort between therapist and client***
5. Pacing and efficient use of time	***CBT is time-limited***
6. Focusing on key cognition and behaviours	***CBT uses primarily uses the Socratic method***
7. Guided discovery	***CBT is problem orientated***
8. Formulation	***CBT is based on the cognitive model of the emotional disorders***
9. Application of cognitive techniques	***CBT relies on the inductive method*** ***CBT is based on an educational model***
10. Application of behavioural techniques	***CBT relies on the inductive method***
11. Homework	***Homework is a central feature of CBT***
12. Eliciting Feedback	***Therapy is a collaborative effort between therapist and client***

It can be seen from the table that there is indeed a good degree of fit between the principles of CBT as described in this chapter and the main skills and methods of CBT as defined by the type of CB skills instrument most used on CBT training courses. The language used for both principles and skills can be cross-referenced closely between the two columns in the table.

4.3.4. The semi-structured interview schedule[8]

Flick (1998, p. 76) makes the case for semi-structured interviews by suggesting that they are "… linked with the expectation that the interviewed subjects' viewpoints are more likely to be expressed in a relatively openly designed interview situation than in the

[8] The Schedule is in Appendix 2.

standardised interview or questionnaire." Even with the less structured interviews, however, there is a range of interview types. Some authors have distinguished between in-depth qualitative and semi-standardised interviews (Fontana & Frey, 2000: May, 2001; Mason (2002) and Patton (2002). May suggests that semi-standardised interviews offer the opportunity to seek clarification and elaboration by using probes. Arthur & Nazroo (2003, p.111) say that:

> In semi-structured or semi- standardised interviews, the interviewer asks key questions in the same way each time and does some probing for further information, but this probing is more limited than in unstructured, in-depth interviews.

Bryman (2004) points out that the semi-standardised interview still follows a script to a certain extent and this may lead to limited responsiveness to individual personal contexts. Limiting probing may also mean that material from confident people gets disproportionate representation in the research data. Despite this caveat, which may in any case apply to all interview situations, the semi-structured interview in this study did anticipate some likely response options – partly, as Arthur and Nazroo (2003) note, because it is likely to result in a more structured data analysis stage.

The interview schedule was developed specifically for the purpose of the study and contained the following sections:

Section A:	Experiences before CBT Training (8 questions); e.g., Question A1: How did your interest in CBT begin?
Section B:	Experiences during CBT Training (6 questions); e.g. Question B10: What aspects of CBT Training did you gain most from?
Section C:	Experiences after CBT Training (6 questions): e.g., Question C15: Would you now describe yourself as a Cognitive Behaviour Therapist?
Section D:	Experience of the actual interview experience itself (2 questions)

The interview schedule allowed for more reflective consideration of how the processes of assimilation and adaptation of training and other information were made during training.

What were the struggles, what made immediate sense and, for example, which CBT principles were never fully accepted? What factors played a role in this learning process – tutor interventions, experiences with clients etc.? What, if any, interaction effects seemed to occur between these learning events – for example, a tutor may have passed a comment about a client situation that led the trainee to implement a successful intervention.

The interview schedule was piloted on three interviewees who were not otherwise involved in this study. One had been trained in Family Therapy; another in a behavioural form of alcohol counselling and one had been a trainee of a previous cohort of the CBT training course surveyed in the study. Several amendments of the schedule were made from comments by the pilot interviewees. The main one concerned the fact that in the original version, the terms 'training' and 'course' were used interchangeably. Data from the pilot interviews indicated that when the term 'course' was used, interviewees were more likely to come up with course-specific responses. When the term 'training' was used, respondents were more likely to refer to generic training processes. As the research was more interested in generic training processes, the final version of the schedule used the term 'training' throughout.

Interviews were timed to last for one hour. The full interview schedule can be seen in Appendix 2.

4.4. Procedure

The researcher spoke to each cohort of trainees in the study when trainees came to enrol for the course one month before their course began. The study was described to the trainees and their co-operation was requested. It was also made clear that they should feel free not to participate and that they were able to withdraw from the study at any time without prejudicing their training. It was also pointed out that, because the data were stored by a member of staff not otherwise involved with the students, the researcher would not know who had and who had not participated until after the end of their studies (see following paragraph). They were also asked to bring a tape of their current practice of CBT with them to the first teaching session so that the researcher

could assess their current competency. The researcher's presentation was followed by a letter again re-explaining the project and asking for the trainee's consent. The letter did not, however, require the trainee to give written consent. It assumed that by returning of the first questionnaire gave consent to join the study. The letter is included with the questionnaire in Appendix 1.

If the questionnaire was not returned, one further copy was sent, along with a letter that explained that non-return of this one would be assumed as not giving consent to join the study and would result on no further requests for information. In retrospect, these arrangements seem inadequate and they will be discussed again during consideration of the limitations of the study in Chapter 7.

4.4.1: Survey and interview

Lists of enrolled trainees in each of the three cohorts were obtained from course administrators. All participants were given a study number and data concerning participants were stored under that number, thus offering a degree of anonymity to participants. The other member of staff in the School was not involved in teaching the CBT trainees (referred to in the previous paragraph) and kept a list of study numbers and the matching names of participants. The author of the study did not know the matches between the study numbers and participants' names until they had completed study in the University. The other member of staff sent out all requests for questionnaire data with a stamped addressed envelope to be returned to him. He was also asked to store information – for example, about which study numbers had responded - in appropriate files before passing data on to the main researcher. The other member of staff was able therefore to support the research procedures by sending out further requests to trainees who had not responded to earlier requests without involving the main researcher. He was also able to supply contact information to either researcher or participant where appropriate (for example, for contact for interview purposes). He was also later able to match up CBT skills assessment results to other data collected by the researcher.

The CBTTQ was sent out to all enrolled students within two weeks of their enrolment and at least two weeks before the commencement of training. A covering letter, including the points covered by the researcher at enrolment was attached to the CBTTQ

questionnaire. All trainees entering the training course in the requisite period were asked to participate initially by filling out the CBTTQ, and again at the end of training and then at one year after completion of training. All training participants who had completed the CBT training and had completed all other academic requirements (most usually a research dissertation) and were willing to be interviewed, were interviewed, either face-to-face or, in two instances, by telephone. Interviews were conducted after the one-year follow-up stage. The interviews were mainly conducted in the participants' homes at times of their convenience. A small number, however, had to come to the University training centre for some other reason and found it convenient to be interviewed there.

Table 4.3: Data collection process, September 2000-July 2004.

	Pre-course Questionnaire administration	Post-course Questionnaire administration	1Year Follow-up Questionnaire administration	Interviews
Cohort 1	September 2000	July 2001	July 2002	September - November 2002
Cohort 2	September 2001	July 2002	July 2003	September - November 2003
Cohort 3	September 2002	July 2003	July 2004	September 2004

The pre-training version of the questionnaire was sent out to the **first cohort** in September 2000. Participants were asked to return the questionnaire by using a stamp-addressed envelope provided within 2 weeks of its receipt. This return period was maintained throughout the study. A small number of reminders were sent out when questionnaires were not returned within this time. Analysis of the pre-training practice tapes submitted by this cohort was carried out in November, 2000. Analysis of practice tapes submitted during the training period (and part of the formally assessed element of the training) was carried out in January and June 2001. The post-training version of the questionnaire was administered in July 2001. The one-year follow up version was administered in July 2002. The semi-structured interviews for this cohort were carried out between September and November 2002.

The same sequence of procedures was carried out with the **second cohort,** starting with the enrolment address and administration of the pre-training CBTTQ questionnaire in September 2001 and finishing with the semi-structured interviews between September and November 2003.

The process with the **third cohort** followed the same procedures up until the one year follow-up administration of the CBTTQ questionnaire in July 2004. Data collection was then terminated in September 2004 after interviews with some available cohort members.

4.4.2: Competence assessment

It is a common procedure on CBT training courses to ask trainees to submit audio or video tapes for assessment using an instrument such as the CTS-R. In this study, trainees were asked to submit tapes immediately before the start of the course (pre-training tapes), at mid-training (mid-training tape) and at the end of training (end of training tape). The pre-training tape was a purely voluntary submission but the mid and end of training tapes were used as part of course assessment. The pre-training assessment assessed both General and Specific CBT skills (as defined in the CTS-R), the mid-training assessment assessed General Therapy skills only and the end of training assessment assessed Specific CBT skills and any General Therapy skills in which the trainee had not shown competence at mid-training. Each tape was assessed by two tutors, one of which was the author, from a team of 3 tutors. Grades awarded by tutors were usually in close agreement. Tutors then discussed their respective grade assessments and accorded an agreed common grade. Occasionally, this involved consultation with the third tutor. For the research project, grades were stored under the student number used in the survey and were not subjected to analysis until trainees had completed their training at the University.

The full data collection cycle for the survey, interviews and competence assessment is shown in Table 4.4.

Table 4.4: Detailed outline of data collection procedures.

DATES	COHORT 1: 2000-1	COHORT 2: 2001-2	COHORT 3: 2002-3
September 2000	Introduce study to participants: Administer Pre-training questi Cohort 1 begins training		
November 2000	CB skill assessment TIME A Pre-training		
January 2001	CB skill assessment TIME B: Mid-training		
June 2001	CB skill assessment TIME C		
July 2001	Cohort 1 ends training: Post-training questionnaire		
September 2001		Introduce study to participants: Administer Pre-training questionnaire: Cohort 2 begins training	
October 2001		CB skills assessment TIME A: PRE	
January 2002		CB skills assessment TIME B: MID	
June 2002		CB skills assessment TIME C: END	
July 2002	Follow-up of training questionnaire	Cohort 2 ends training: Post-training questionnaire	
September 2002	Semi-structured interviews		Introduce study to participants: Administer Pre-training questionnaire: Cohort 3 begins training
October 2002	Semi-structured interviews		CB skills assessment TIME A: PRE
November 2002	Semi-structured interviews		
January 2003			CB skills assessment TIME B: MID
June 2003			CB skills assessment TIME C: END
July 2003		Follow-up of training questionnaire	Cohort 3 ends training: Post-training questionnaire
August 2003		Semi-structured. interviews	
September 2003		Semi-structured interviews	
October 2003		Semi-structured interviews	
July 2004			Follow-up of training questionnaire
September 2004			Semi-structured. interviews

4.5: Ethical aspects of the study

At the time the study was undertaken, there was no formal requirement to seek ethical permission in either the University where the study was undertaken or in the University in which it was supervised. It was, however, recognised that certain ethical issues were connected with researching amongst trainees with whose training the author was connected. Efforts to safeguard the rights of consent and confidentiality have already been described in the section on procedure.

With these issues in mind, the study proposal and methods were presented to the research committee of School of the University in which it took place and the ethical aspects of it were examined and discussed. The author made several subsequent presentations about the on-going work of the study to the research committee and the School. The study was conducted in adherence with the code of ethics for research in counselling and psychotherapy, published by the British Association for Counselling and Psychotherapy (BACP, 1996). Further aspects of the ethical approach taken to this research, including discussion of its limitations is included in Section, 7.6 of the final chapter.

4.6. Data Analysis

4.6.1: Analysis of Quantitative Data

Quantitative analysis was undertaken using the SPSS statistical package (Fourteenth Edition). Frequency analyses were used to explore the nature and spread of the collected data. Tests of association, such Chi-square and Spearman's-rho, and tests of difference such as ANOVA, were used to establish if there were significant differences between sub-groups of the trainee cohorts: for example, whether students with different pre-existing therapeutic orientations performed differently when assessed for competency in the skills being taught.

4.6.2: Analysis of Qualitative Data

Analysis was carried out using framework analysis (Ritchie & Lewis, 2003). The basic process of framework analysis involves iterative oscillation between text and developing categorisation (Charmaz, 1995). The first step involved scrutinising the texts and constructing a framework index of terms likely to prove useful in evolving categories for data analysis. A matrix was then constructed in which the columns represent the individual questions of the interview schedule and in which the rows consist of individual cases or respondents. Entries into the matrix stuck as closely as possible to the respondents' own language. The matrix was edited to bring together responses with thematic similarity and then used to produce thematic charts. The on-going process of data analysis was iterative, oscillating between categorisation and raw text. The analyst at this stage was looking for categories that give a good purchase on the data and, for example, explain, differences between categories (Hammersley & Atkinson, 1995). The

first iterative cycle results in the construction of thematic charts (Ritchie & Lewis, 2003) in which key issues are isolated and the themes of the index are elaborated and refined. This was active process and it is inevitable with human researchers that there will be some degree of construction of meaning (Miles & Huberman, 1994). These constructions should, however, be testable in some way: for example by comparison with other data or existing theory (Denzin, 1994).

The semi-structured interviews were structured around three key themes: the decision to undertake training in CBT (the pre-training phase); experiences during training in CBT (the training phase) and the evolution of practice since training in CBT (the post-training phase). The major cross-cutting theme was the way previously held theories of psychotherapy influenced each one of these phases. For each of these categories, the author wrote respondent answers onto cards and then sorted the cards into sub-themes. After the first card sort, the overall sub-themes were re-examined and resorted to allow consolidation of some categories and amendments to others. A third card sort made final adjustments to the categories and sub-themes, ready for presentation to a group of colleagues, described below.

The author made a presentation of the initial categories that emerged from his first analysis to a group of 8 colleagues involved in CBT teaching, including some who had trained in the course under study. Transcripts were also made available to the group members who were asked to read them and join a discussion of the themes that seemed evident in them. The group made useful suggestions about the categories proposed by the author, suggesting modifications and new possible categories to consider. One consistent theme mentioned by group members was the difference between trainees influenced by different modalities and how these varied over time. These categories remained through the subsequent phases of iterative analysis and were evolved into the 12 thematic charts and elaborated by framework analysis (Ritchie & Lewis, 2003).

Twelve thematic charts were therefore created for the four approaches to psychotherapy held by trainees for the responses to each of the three phases of the study. The charts,

along with a central thematic chart, which integrated all the themes of the charts into one central figure (Ritchie & Lewis, 2003), are presented in Chapter 6.

The process of selecting out respondent statements inevitably has some subjective features. The reader, however, will have the opportunity to check the selections made in the thematic charts located in Chapter 6.

Chapter 5: Attitude and Skill Development during CBT training

This chapter describes and analyses data collected by the Cognitive Behaviour Therapy Training Questionnaire (CBTTQ) and the Cognitive Therapy Scale Revised (CTS-R). The CBTTQ data show a group of mature students with varied educational and professional backgrounds entering CBT training with varied attitudes towards the principles of CBT. It charts the development of these attitudes during the course of training. The CTS-R data chart the development of CBT practice skills amongst the same trainees. Finally, the chapter explores the relationship between the attitudes, their development and the acquisition of CBT practice skills.

The chapter will begin by describing the general features of the participants involved in the study. As each variable is introduced, it will be initially shown for the three cohorts involved in the study. This is to demonstrate near equivalence between each cohort sample. After the description of the general features of the study sample, data directly related to three of the four research questions of the study will be presented. Data analysis was conducted using SPSS for Windows, version 14. The analysis of qualitative data relating to the fourth research question is presented in Chapter 6.

5.1: Demographics:

The sample comprised of trainees recruited by a single training centre in 3 consecutive annual cohorts. The initial sample size was of 55 participants, who responded to the pre-training questionnaire. There was a small amount of attrition over the period of the study so that the sample size was 51 for the post-training survey and 48 for the follow-up survey. The distribution of participants by gender at each cohort intake is shown in Table 5.1.

Table 5.1: Gender: by cohorts

	Cohort 1	Cohort 2	Cohort 3	TOTAL
Female	18 (90%)	14 (82%)	13 (72%)	45 (82%)
Male	2 (10%)	3 (18%)	5 (28%)	10 (18%)
TOTAL	20 (100%)	17 (100%)	18 (100%)	55 (100%)

The mean age of the respondents at the start of training was 45.78 years (SD = 7.59). The ages of respondents ranged from 30 to 58 years. Age-groups for trainee cohorts by age at the start of training is shown in Table 5.2.

Table 5.2: Distribution of gender by age groups at each time intake

		Cohort 1	Cohort 2	Cohort 3	Total
30-39	Female	3 (15%)	1 (6%)	6 (33%)	10 (18%)
	Male	0	0	0	0
40-49	Female	8 (40%)	9 (53%)	4 (22%)	21 (38%)
	Male	1 (5%)	2 (12%)	2 (11%)	5 (9%)
50-59	Female	7 (35%)	4 (24%)	3 (17%)	14 (25%)
	Male	1 (5%)	2 (12%)	2 (11%)	5 (9%)
TOTAL		20 (100%)	17 (100%)	18 (100%)	55 (100%)

5.2: Education and Employment

Study participants were mature students from varied educational and occupational backgrounds (Tables 5.3 and 5.4). Participants were relatively evenly divided between graduates and non-graduates. Entry criteria for the training course on which the study is based required that applicants should already have completed a course in counselling to Diploma level. They almost all held professional qualifications in counselling and almost 60% of them combined this with professional qualifications from other helping professions, including nursing, social work and youth work. A small number of trainees were admitted using Accreditation of Prior Achievement when they had been in work and training situations in which key elements of counselling training had been achieved.

Table 5.3: Educational Background at Pre-training by cohorts

	Cohort 1	Cohort 2	Cohort 3	TOTAL
GCSE only	9 (45%)	1 (6%)	5 (28%)	15 (27%)
A-level only	4 (20%)	5 (29%)	4 (22%)	13 (24%)
Undergraduate degree	7 (35%)	9 (53%)	7 (39%)	23 (42%)
Postgraduate degree	0	2 (12%)	2 (11%)	4 (8%)
TOTAL	20 (100%)	17 (100%)	18 (100%)	55 (100%)

Table 5.4: Professional Qualifications by cohorts:

	Cohort 1	Cohort 2	Cohort 3	TOTAL
Counselling /nursing	5 (25%)	6 (35%)	5 (28%)	16 (29%)
Counselling/social work	4 (20%)	4 (24%)	2 (11%)	10 (18%)
Counselling/ other helping profession	2 (10%)	2 (12%)	2 (11%)	6 (11%)
Counselling only	9 (45%)	5 (29%)	6 (33%)	20 (36%)
Helping profession only	0	0	3 (16%)	3 (5%)
TOTAL	20 (100%)	17	18	55 (100%)

Table 5.5 shows data about the work status of study participants. Thirty six of the sample described themselves as employed full time and the others described themselves as either employed part-time or self-employed. There was one person who was not employed.

Table 5.5: Employment status by cohorts

	Cohort 1	Cohort 2	Cohort 3	TOTAL
Full-time employed	12 (60%)	9 (53%)	15 (83%)	36 (67%)
Part-time employed	3 (15%)	2 (12%)	1 (6%)	6 (11%)
Self-employed	5 (20%)	6 (35%)	1 (6%)	12 (21%)
Not employed	0	0	1 (6%)	1 (1%)
TOTAL	20 (100%)	17 (100%)	18	55

Tables 5.6 & 5.7 describe aspects of the participants' patterns of employment. Thirty of the initial sample defined their job roles as 'counsellor' and 20 saw themselves as practising counselling as part of their work role in jobs such as nurses or social workers. Five trainees were in other jobs such as office work but wanted to move into counselling work. Most trainees had been in their present jobs for less than 5 years and previously to that had been in non-counselling posts.

Table 5.6: Present Work Role by cohorts

	Cohort 1	Cohort 2	Cohort 3	TOTAL
Counsellor	15 (75%)	10 (59%)	5 (28%)	30 (55%)
Helping profession	5 (25%)	5 (29%)	10 (56%)	20 (36%)
Other	0	2 (12%)	3 (17%)	5 (9%)
TOTAL	20 (100%)	17	18	55 (100%)

Table 5.7: Time in Current Post by cohorts

	Cohort 1	Cohort 2	Cohort 3	TOTAL
Less than 1 year	4 (20%)	4 (24%)	6 (33%)	14 (25%)
1 - 4.years	11 (55%)	10 (59%)	9 (50%)	30 (55%)
5 - 9years	3 (15%)	2 (12%)	3 (17%)	8 (15%)
10 & more years	2 (10%)	1 (6%)	0	3 (5%)
TOTAL	20 (100%)	17 (100%)	18 (100%)	55 (!00%)

In summary, the trainee sample was mainly female and of mature age. Questions Biv) and Bv) asked what trainees what they hoped to do after training. Their answers showed that they had gravitated towards counselling work within the last five years and saw CBT training as an opportunity to refine their skills and move into more specialist areas of counselling work.

5.3: Employers' support of trainees undertaking training in CBT

Jobs carrying the descriptor 'counsellor' are relatively recent arrivals in the employment field (Woolfe & Dryden, 1996; McLeod, 2003). Unlike professions such as social work and clinical psychology, counsellors have not had natural and large employment bases such as in local government or the NHS.

Tables 5.8, 5.9 and 5.10 describe different aspects of the degree to which employers gave priority to CBT training and supported trainees to undertake it. Employer support has practical and psychological aspects. Employers can provide support by such practical steps as helping with training fees and by giving trainees leave to attend training sessions. As can be seen in the tables 5.8 and 5.9, trainees in this study only rarely had such practical support. Only 12 out of 55, for example, had all or even part of their training course fees paid by employers. 20 of 55 were given leave to attend the course, whilst others had to take unpaid leave or leave from their holiday allocation. Employers may, however, also be encouraging in other ways. Trainees reported themselves as experiencing quite high levels of general support from employers (Table 5.10). The data here may be influenced by the complexity of some of the employment patterns revealed during the semi-structured interviews, the data for which is presented in the next chapter.

Table 5.8: Course fee paid by employer

	Cohort 1	Cohort 2	Cohort 3	TOTAL
Course fee paid	4 (20%)	3 (18%)	5 (28%)	12 (22%)
Course fee not paid	16 (80%)	12 (71%)	12 (67%)	40 (73%)
Self-employed	0	2 (12%)	1 (5%)	3 (4%)
TOTAL	20 (100%)	17 (100%)	18 (100%)	55 (100%)

Twelve respondents defined themselves as 'self-employed' (Table 5.5) yet in answering the question on employer support only 3 respondents exempted themselves from answering because of this status. It appears then that 9 respondents who had previously defined themselves as 'self-employed' also regarded themselves as having legitimate expectation of practical support from employers who might employ them for sessional or occasional work.

Table 5.9: Employers' granting leave to attend training course

	Cohort 1	Cohort 2	Cohort 3	TOTAL
Granted	7 (35%)	5 (29%)	8 (44%)	20 (36%)
Not granted	13 (65%)	10 (59%)	9 (50%)	32 (58%)
Self-employed	0	2 (12%)	1 (6%)	3 (5%)
TOTAL	20 (100%)	17 (100%)	18 (100%)	55 (100%)

Table 5.10 shows trainees' estimates concerning perceived degrees of employer support and the priority accorded to CBT training by employers. It should be noted that the response rate for these questions was lower than in the rest of the survey. The employers' support towards trainees was rated as slightly higher than their sense of priority for CBT training. It is, however, interesting to note that employer support is rated highest by cohort 3, which had the highest degree of actual practical support of the three cohorts. The increased practical support for trainees in cohort 3 may be a small sign of employers exhibiting a growing recognition of the desirability of CBT training.

Table 5.10: Mean ratings of trainees' estimates of employers' supportiveness and priority given to CBT training by trainees defining themselves as employed (n=43)

	Cohort 1 (n=15)	Cohort 2 (n=11)	Cohort 3 (n=16)	All cohorts (n=42)
Employer priority*	2.40	2.43	2.43	2.42
Employer support*	2.60	2.57	2.71	2.63

*(Ratings: 1 = Weak; 2 = quite weak; 3= quite strong; 4 = strong)

In summary, the respondents' reports of employers' attitudes towards their efforts to be trained in CBT did not show much of a sense of priority for specific training in that modality. Whilst employers showed some levels of support and priority for the training that the trainees were undertaking, it was not clear whether this was because it was training in CBT or merely any training that contributed to the trainees' career and/or personal development.

5.4: Preferred model of therapy

The questionnaire asked the trainees about their preferred models of therapeutic practice. Table 5.11 shows how trainees described their preferred model of therapy at the pre-training stage:

Table 5.11: Preferred therapy model at pre-training

	Cohort 1	Cohort 2	Cohort 3	TOTAL
Cognitive Behaviour Therapy (CBT)	3 (15%)	2 (12%)	3 (17%)	8 (15%)
Person-centred Therapy (PCT)	10 (50%)	9 (53%)	7 (39%)	26 (47%)
Psychodynamic Therapy	6 (30%)	1 (6%)	0	7 (13%)
Integrated/Eclectic Therapy	1 (5%)	5 (29%)	8 (44%)	14 (25%)
TOTAL	20 (100%)	17	18	55

Preferences in relation to therapeutic models are important to the research questions in this thesis because the questions sought to trace whether trainees with different preferences responded differently to training. Descriptor name choices, however, do not necessarily tell all the story of their actual preferences. At various points in the history of psychotherapy, it has been pointed out that there may be discontinuities between the way therapists describe their practice and the *actual* way that they practice (Ivey et al, 1997). The response of trainees to CBT principles, both as individual principles and as an aggregated score of responses to the principles, offered another insight into their beliefs about their practice.

Responses to each principle of the CBPI were scored between 1, recording strong disagreement with the CBT principle, and 4, recording strong agreement with the principle[1]. As there were 10 CBT principles to respond to, scores could vary between 40, for full strong agreement with the principles, and 10, strong disagreement agreement with them. Table 5.12 shows the results of how trainees from different modality preferences scored on the CBPI.

Table 5.12: Mean CBPI scores for different modality preferences at pre-training (n=55)

	N	Mean	SD	Range
CBT	8	34.75	2.82	30-39
PCT	26	28.82	4.89	21-34
Psychodynamic	7	28.57	3.10	24-33
Integrated/Eclectic	14	31.79	4.26	27-36
All	55	30.40	4.74	21-39

[1] As shown in 4.3.1.1

The mean aggregated score for all 55 trainees responding to the pre-training questionnaire was 30.40 (SD = 4.74) which shows that support for CBT principles was generally quite high at pre-training. The mean scores for subgroups of trainees preferring the various descriptor name choices were: 'CBT' = 34.75 (n=8; SD = 2.82); 'Integrated/Eclectic' therapy (NB These trainees frequently named CBT as a key element of their approach) = 31.79 (n=14; SD= 4.26),'Person-centred' and 'Psychodynamic' therapy, traditionally most critical of CBT, 28.81 (n=26; SD=4.89) and 28.57 (n=7, SD = 3.10) respectively. One way ANOVA analysis of variance showed the differences between the mean scores were significant (F (3, 51) = 4.80, significance, p = .005), there being less than 5 chances in 100 that the differences had arisen by chance. Table 5.13 shows multiple comparisons using the Bonferonni[2] correction show a significant difference, p < .05, between CBT & PCT and between CBT and Psychodynamic therapy.

Table 5.13: Multiple and integrated comparisons of mean CBPI score by different model preference at pre-training (n=55) using ANOVA with the Bonferonni correction:

Comparison of:	With:	Mean difference	Std Error	Sig.
CBT	PCT	5.94*	1.74	.008
	Psychodynamic	6.18*	2.23	.047
	Integrated	2.96	1.91	.762
PCT	CBT	-5.94*	1.74	.008
	Psychodynamic	.24	1.84	1.00
	Integrated	-2.99	1.43	.253
Psychodynamic	CBT	-6.18*	2.23	.047
	PCT	-.24	1.84	1.00
	Integrated	-3.21	2.00	.680
Integrated	CBT	-2.96	1.91	.762
	PCT	2.99	1.43	.253
	Psychodynamic	3.21	2.00	.680

* The mean difference is significant at the .05 level.

In summary, trainees beginning this course of training in CBT described their preferred model of therapy in various terms, the majority of which were not CBT. Trainees preferring the four different main models of therapy showed significantly different responses to a measure of agreement with CBT principles – the CBPI. Trainees preferring the CBT model showed significantly more positive responses to CBT principles than trainees preferring both the PCT and Psychodynamic models.

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[2] The Bonferroni test is the appropriate test for small numbers of multiple comparisons. It helps to guard against Type 1 errors by keeping the overall Type 1 error rate at .05 (Field, 2000).

5.5: Research Question A: Attitude change towards CBT principles during training and at one year follow up

The following section presents data showing the way trainees reported their attitudes towards the various individual CBT principles operationalised in the Cognitive Behavioural Principles Inventory (CBPI) section of the CBTTQ before and after training and at one year follow-up. The data shows the degree to which trainees found themselves in agreement with CBT principles and how this degree of agreement developed over time. The movement of the attitudes was generally towards a higher degree of agreement with CBT principles over the time of the training and follow up periods. Firstly, the reliability of the measure is considered. Secondly, a description of changes in aggregated mean scores of the measure over time is reported. Thirdly, changes in individual principles over time are described.

5.5.1: Reliability of the Cognitive Behavioural Principles Inventory (CBPI)

Cronbach's alpha measures how well a set of items measures a single, unidimensional latent construct. When data has a multidimensional structure, Cronbach's alpha will usually be low. Helms et al (2006) describe good practice for the use of Cronbach's alpha coefficient for summated scales. Cronbach alpha and other reliability scores were calculated for the Cognitive Behavioural Principles Inventory (CBPI) data for each stage of its administration and overall. The scores for Cronbach's alpha and, for the sake of comparison, Gutman half-split[3] and the Spearman-Brown[4] are shown in Table 5.14:

Table 5.14: Reliability of the CBPI (10 items)

	Cronbach alpha scores	Gutman half-split[5]	Spearman Brown[6]
Pre-training (n=55)	0.842	0.845	0.857
Post-training (n=51)	0.783	0.783	0.784
Follow-up (n=48)	0.808	0.753	0.753
All stages	0.872	0.855	0.861

[3] The Gutman half-split coefficient is an alternative reliability measure calculated by comparing responses on one half of a scale with the other.
[4] The Spearman-Brown coefficient is also a split-half measure but also estimates the effects of lengthening and shortening a scale.

These scores are all over 0.75 and therefore high enough to suggest that the measure has minimal reliability for the data to be aggregated for analysis (Helms et al, 2006; Hinton, et al, 2004; Streiner & Norman, 2003). Alpha scores were also calculated for the various possible of combinations of 9 of the 10 principles at the three different times of administration. All of these 30 alpha scores were above 0.75 and ranged from 0.752 to 0.844.

5.5.2: Changes in mean CBPI scores over the period of training and follow-up

Means were calculated for the aggregated scores of all principles and were then compared and analysed using a repeated measures analysis of variance (ANOVA), with time as a within participants factor. Table 5.15 presents the mean scores and Table 5.16 summarises the results of the ANOVA analysis.

Table 5.15: Means of CBPI scores at different stages of training

	Pre-training (N=48)	Post-training (N=48)	Follow-up (N=48)
CBPI score	**3.08 (SD= .42)**	**3.51 (SD= .38)**	**3.44 (SD= .35)**

The interpretation of the following repeated measures ANOVA calculations follows the SPSS procedure suggested by Hinton et al (2004) who advise that data should be tested for sphericity, using Mauchly's test. If the Mauchly's W score produces a significant result, then sphericity cannot be assumed. In this instance, the W score is 0.858 and is significant, $p < 0.05$. In this situation, Hinton et al recommend checking the Greenhouse-Geisser epsilon score, which if close to 1.0 can allow us to assume sphericity. The epsilon score is 0.876. If we regard this as close to 1.0, then the Sphericity Assumed F-score is 25.931 and is significant, $p < 0.05$. Alternatively, a multivariate test, such as Wilks' Lamda, makes fewer assumptions about the data and is therefore less vulnerable to problems of sphericity. The Wilks' Lamda F-score for the above change in mean CBPI scores over time is: **$F(2, 46) = 25.93$, $p < 0.0001$.** The ANOVA analysis is presented in Table 5.16. As both these ways of calculation result in highly significant F-scores, this allows us to conclude that there are significant differences in the mean total CBPI scores generated by administrations at different stages of the training.

Table 5.16: One factor repeated measures ANOVA Analysis of CBPI mean scores:

Sphericity tests	Mauchly's W	Mauchly's Sig.	Greenhouse-Geisser Epsilon	Greenhouse - Geisser F-value, Sig.
	0.858	0.03	0.876	36.473 (.0001)
F-scores	Sphericity Assumed	Df, sig.	Wilkes Lamda	Df, sig.
	25.931	2, 48, (.0001)	25.931	2, 48 (.0001)

Table 5.17 presents post-hoc analysis comparing mean changes using the Bonferroni correction. It shows that there are significant differences between mean group scores on CBPI between pre-training and post-training, pre-training and follow-up but not between post-training and follow-up. The training period is associated with significant attitude change in trainees between pre-training and post-training and that these changes largely maintain themselves until at least one year after training.

Table 5.17: ANOVA Post-hoc Analysis of CBPI mean scores using the Bonferroni correction:

Compare Mean CBPI score of	With	Mean difference	Sig.
Pre-training	Post-training	-4.35	<.0001
Pre-training	Follow-up	-3.65	<.0001
Post-training	Follow-up	0.71	.>.05

In summary, the data show that there were significant changes in the attitudes towards agreement with CBT principles over the period of training and that the training process itself is likely to be associated with changes in positive regard for CBT principles. It is also shows that these changes are maintained at follow-up and that there is no significant reversion to previous attitude structures between the end of training and at least one year later.

5.5.3: Changes in attitudes towards individual CBT principles

The CBP Inventory consisted of ten individual CBT principles. It is important to examine the development of individual principles over time because there is variation in the level to which trainees express levels of agreement with the various principles at pre-training and it is germane to the research questions posed in this study to observe the amount of variation that is retained or is narrowed over time and whether these changes themselves show similar or different patterns amongst the various principles.

Table 5.18 presents changes in mean scores for individual principles at pre-training, post-training and follow-up and accompanying repeated measures ANOVA analysis. Trainee agreement with all the individual principles showed significant increases, $p < 0.05$, during training. These changes were largely maintained at follow-up. Table 5.19 shows post-hoc pair-wise analysis, using the Bonferroni correction, conducted on the differences between pre and post scores, pre and follow-up scores and post and follow-up mean scores for each of the principles. This analysis shows that there were significant differences, $p < 0.05$ in mean scores for each principle between pre-training and post-training and between pre-training and follow-up but not between post-training and follow-up. There was one exception to this trend and that was the principle stressing the importance of keeping therapy brief. In this case, there was a significant difference between pre-training and post-training but not between pre-training and follow-up. This implies that agreement with this principle showed a degree of reversion towards pre-training attitudes held by trainees.

Table 5.18: Mean cores for the 10 CBT principles over time with repeated measures ANOVA analysis, *SD in parenthesis*:

Principle	Pre-training (n=48)	Post-training (n=48)	Follow-up mean (n=48)	F values for df (2,96)	Significance level
1. The importance of Formulation.	2.90 (.78)	3.67 (.60)	3.48 (.58)	19.98	.0001
2. The importance of the therapeutic relationship	3.23 (.75)	3.58 (.64)	3.56 (.54)	5.77	.004
3. The importance of collaboration	3.46 (.62)	3.79 (.41)	3.77 (.43)	9.84	.0001
4. The importance of goal direction	3.02 (.73)	3.56 (.54)	3.38 (.61)	14.59	.0001
5. The importance of present time focus	2.94 (.70)	3.21 (.74)	3.21 (.58)	4.94	.009
6. The importance of the educational function	3.38 (.57)	3.69 (.46)	3.67 (.56)	6.75	.002
7. The importance of brief therapy	2.83 (.78)	3.35 (.60)	3.10 (.52)	11.71	.0001
8. The importance of structure	2.75 (.81)	3.40 (.54)	3.38 (.49)	23.61	.0001
9. The importance of focusing on cognition	3.10 (.66)	3.73 (.45)	3.56 (.54)	20.30	.0001
10. The importance of setting homework	2.88 (.79)	3.48 (.55)	3.40 (.57)	17.05	.0001

Table 5.19 Pair wise comparisons of mean differences in principles ratings at pre, post and follow-up, using the Bonferonni correction: Mean difference and (significance in brackets)

	Pre-Post comparison	Pre-Follow-up comparison	Post-Follow-up comparison
1. Formulation	.60 (.0001)*	.58 (.001)*	.19 (.32)
2. Therapeutic relationship	.63 (.0001)*	.33 (.036)*	.02 (1.00)
3. Collaboration	.33 (0.35)*	.31 (.003)*	.02 (.70)
4. Goal-direction	.54 (.002)*	.35 (.003)*	.19 (.093)
5. Present time focus	.27 (.032)*	.27 (.042)*	.00 (1.00)
6. Educational focus	.31 (.003)*	.29 (.014)*	.21 (.10)
7. Brief therapy	.52 (.0001)*	.27 (.093)	.25 (.04)*
8. Structure	.65 (.0001)*	.63 (.0001)*	.02 (.083)
9. Cognitive focus	.63 (.0001)*	.46 (.0001)*	.17 (.091)
10. Homework	.60 (.0001)*	.52 (.0001)*	.08 (.97)

5.6: Research Question B: Changes in individual CBT competencies during training:

A tradition of training assessment for CBT has developed by appraising the use of skills via standardised measures that rate the extent and quality of skill use as evidenced by trainee performances in sessions recorded on audio or videotape. In this study, such assessments of the skills of 3 successive cohorts of trainees were made at pre-training, mid-training and end of training during CBT training in 3 successive academic years. The data presented below shows which CB skills trainees were assessed as possessing prior to training and, conversely, which ones still needed to be achieved. The general pattern of skill acquisition was one of fairly rapid gain in competence as training progressed. As might be expected, some skills proved more difficult to master than others. Nevertheless, most trainees had acquired most of the stipulated skills by the end of training. Some trainees, however, found particular skills hard to master and thus had to submit extra assessment tapes after the end of training. Inevitably they took longer to acquire competence in the full range of CBT skills.

5.6.1: The form of CBT skills assessment

General therapy skills[7] of the CTS-R were assessed at mid-training ('mid-training assessment') and Specific CBT skills[8] of the CTS-R were assessed at the end of training ('end of training assessment'). General therapy skills in which trainees had been deemed as not yet competent at mid-training could be re-assessed at the end of training. Any general or specific skills in which competence was not achieved by the end of training could be re-assessed on one further occasion before the commencement of the next academic year ('final assessment').

For the purposes of the research project, trainees were asked to submit an audiotape of an attempt to do what they considered to be CBT before the commencement of training (pre-training assessment). This was done on a voluntary basis and could not result in any training credit. The tapes were assessed for the degree to which trainees exhibited both General Therapy and Specific CBT skills. Pre-training, mid-training, post-training and final assessment results for the 41 trainees who did submit pre-

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[7] CTS-R General therapy skills include: Agenda setting; Eliciting feedback; Collaboration; Pacing and Interpersonal effectiveness.

[8] CTS-R Specific CBT skills include: Eliciting emotions; Eliciting key cognitions; Eliciting behaviours; Guided Discovery; Formulation; Application of change methods, and, Setting homework.

training tapes are presented in Table 5.20, with accompanying ANOVA analysis. 14 trainees in the study did not submit pre-training tapes but did submit tapes at later stages. A trainee skill mean competence score was calculated by dividing the number of trainees achieving competence by the number of all trainees taking each assessment, therefore mean scores close to 1.0 indicate high rates of achieving competence and those close to 0.0 indicate low rates of achieving competence.

The data presented in this section will begin by describing the skill assessment results for the 41 trainees who submitted tapes to be appraised at the pre-training stage and then their results as they moved through subsequent phases of training. There will then follow analysis of the results for 14 trainees who did not submit pre-training tapes but did submit tapes at subsequent stages of assessment.

Table 5.20: CBT Skills Assessment: Trainee rates of achieving competence at all Stages (n=41):

A. CBT skills (as per CTS-R)	B. Mean (& SD) competence grades per trainee: Pre-training	C. Mean (& SD) competence grades per trainee: Mid-training	D. Mean (&SD) competence grades per trainee: End-training	E. ANOVA F-ratio Degrees of freedom, (Significance)
General Therapy skills				
1. Agenda-setting	0.32 (.47)	0.66 (.48)	-	F (1, 40) = 17.43 (.0001)*
2. Feedback	0.27 (.45)	0.90 (.30)	-	F (1, 40) = 48.81 (.0001)*
3. Collaboration	0.93 (.26)	0.85 (.36)	-	F (1, 40) = 1.30 (.262) n.s
4. Pacing	0.56 (.50)	0.95 (.22)	-	F (1, 40) = 21.25 (.0001)*
5. Interpersonal effectiveness	1.00 (.00)	0.98 (.16)	-	F (1, 40) = 1.00 (.323) n.s
Specific CBT skills				
1. Eliciting emotions	0.93 (.26)	-	1.00 (.00)	F (1, 40) = 3.16 (.083) n.s
2. Eliciting key cognitions	0.76 (.44)	-	0.95 (.44)	F (1, 40) = 7.40 (.010)*
3. Eliciting behaviours	0.27 (.45)	-	0.80 (.40)	F (1, 40) = 46.32 (.0001)*
4. Guided discovery	0.07 (.26)	-	0.88 (.33)	F (1, 40) = 165.00 (.0001)*
5. Formulation)	0.24 (.44)	-	0.83 (.38)	F (1, 40) = 147. 79 (.0001)*
6. Application of change methods	0.32 (.47)	-	0.88 (.33)	F (1, 40) = 42.66 (.0001)*
7. Setting homework	0.66 (.48)	-	0.93 (.26)	F (1, 40) = 11.75 (.001) *

- Significance $p < .05$

Repeated measures ANOVA analysis shown in Table 5.19 indicates the significance of the changes in mean scores between pre-training (Column B), mid-training-training

(Column C), and end of training (Column D) for those 41 trainees who submitted tapes at all these stages. Table 5.19 shows ANOVA results (Column E) significant increases, at least $p < 0.05$, in the number of trainees achieving competence for 9 of 12 skills listed in the CTS-R. The 9 skills listed in the categories of General Therapy skills and Specific CBT skills are:

General Therapy skills:

- Agenda-setting & adherence,
- Feedback, and,
- Pacing & efficient use of time.

Specific CBT skills:

- Eliciting key cognitions,
- Eliciting behaviours,
- Guided Discovery,
- Conceptual integration (Formulation),
- Application of change methods, and,
- Setting homework.

Changes in the mean competence rates for the three other skills – Collaboration, Interpersonal effectiveness and Eliciting emotions - are not significant. This is due to the fact that mean competence rates at pre-training, 1.00 and 0.93 respectively, were already very high.

5.6.2: Pre-training CBT Skill Assessment

41 trainees submitted tapes at the pre-training stage. The results for the assessment of the individual skill items as represented in these tapes have already been presented in Table 5.19, column B. It can be seen that competence rates for Collaboration and Interpersonal effectiveness were very high at pre-training, with almost all trainees showing competence in them. Over half trainees showed competence at Pacing, whilst under a third did so at Agenda-setting and Eliciting Feedback.

5.6.3: Mid-training assessment of General Therapy skills:

At mid-training, General Therapy skills only were assessed. The results are shown in Table 5.19, column C. It should be noted that the figures presented in that table for mid-training assessment represent only those trainees who presented a tape for pre-training assessment (n=41). Trainees showed marked gains in those skills that had lower competence rates at pre-training and showed a slight decline in competence in areas where competence rates had been very high at pre-training.

Table 5.21 shows how trainees who had made a pre-training submission fared at their first and second attempts at demonstrating general therapy skills by cross-tabulating results at pre- and mid-training:

Table 5.21: Trainees' General Therapy Competence at Pre-training & at Mid-training: (n=41):

A. CBT general skills (As per CTS-R)	B. Achieved competence at pre-training & mid-training	C. Achieved competence at pre but not at mid-training	D. Did not achieve competence at pre but did at mid-training	E. Achieved competence at neither pre nor mid-training
1. Agenda setting & adherence	12	1	15	13
2. Feedback	9	2	28	2
3. Collaboration	33	5	2	1
4. Pacing & efficient use of time	22	1	17	1
5. Interpersonal effectiveness	40	1	0	0

Column D in Table 5.21 shows that there were big increases in the number of trainees achieving competence in Agenda setting & adherence; Feedback, and, Pacing & efficient use of time between the pre-training assessment and mid-training assessments. Interpersonal effectiveness and Collaboration began with high mean competence rates and both showed a slight deterioration at mid-training.

Column E in Table 5.21 allows us to compare the relative improvements in the number of trainees achieving competence in Agenda setting & adherence and Pacing & efficient use of time at mid-training. It is noticeable that more trainees failed to achieve competence in Agenda setting & adherence a second time than for any other general skill. The fact that 13 trainees did not achieve competence looks striking but it

must be remembered that this was the first formal assessment of this skill and that this number of failures had accumulated over three cohorts. The difficulty that trainees had in structuring therapy was also one of the motivating factors for the study as reported in Chapter 1. Only 1 of the 18 trainees who did not achieve competence in Pacing & efficient use of time at pre-training did not achieve competence at mid-training, compared to 11 of the 28 trainees who did not achieve competence in Agenda setting & adherence at pre-training and also not at mid-training.

There were assessment sheet reports, which offered reasons for failures, and these were analysed by the researcher. This analysis adopted line-by-line scrutiny to establish key categories and themes in the assessor's comments. This showed that whereas the majority of trainees did not achieve competence at pre-training because they showed no attempt to set any kind of agenda, the majority of the trainees who did not achieve competence at mid-training were failed because they either did not set an appropriate agenda or failed to adhere to the agenda that had been set. Several different tasks, it is evident, are nested within the overall criteria for this skill. At pre-training, trainees tended to fall at the first fence: i.e., setting any kind of agenda - and so could not be assessed for the further criteria of ensuring a relevant agenda and sticking to it. Other comments made by assessors concerned the quality and relevance of agenda items. In the CTS-R Manual, James et al (2000) comment that agenda items should be clear, discrete and relevant as opposed to vague and irrelevant. Assessors sometimes accepted that agenda items had been set but in some cases queried the clarity and relevance of these items in some tapes and rated them as not showing competence.

5.6.4: End-of-training skills assessments

The results at end of training for trainees who also submitted a pre-training tape have already been reported in Table 5.20, column D. These results showed big gains in competence rates for Specific CBT skills compared to pre-training results, though some trainees were not rated as competent in them. The ANOVA analyses in Table 5.21 shows the gains were significant, $p < 0.05$, in the mean competence rates of trainees for all specific CBT skills, except Eliciting emotions at the end of training, compared to the pre-training stage.

Two further aspects of end-of-training CB skill assessment will be described. Firstly, the re-assessment of those trainees who had not achieved competence in one or more of the five General Therapy skills assessed at mid-training will be described. Secondly, a comparison will be made between how trainees assessed in the various Specific CBT skills at pre-training and how they fared at end of training assessment.

5.6.4.1: End of training reassessment of General Therapy skills:

21 of the 41 (51.2%) trainees who submitted pre-training tapes achieved competence in all 5 General Therapy skill items at mid-training assessment, 20 (48.8%) therefore had to be re-assessed in these items. 16 trainees had to be re-assessed on just 1 item (most usually agenda-setting & adherence), 2 on 2 items, 1 on 3, 1 on 4 items. Thus the total number of trainee skill items being reassessed was 27. The results of re-assessment of these 21 general skills items at the end of training are reported in Table 5.22:

Table 5.22: End of training assessment of the CBT general skills not achieved at mid-training (Trainee n = 20, being assessed on n=27 skill items):

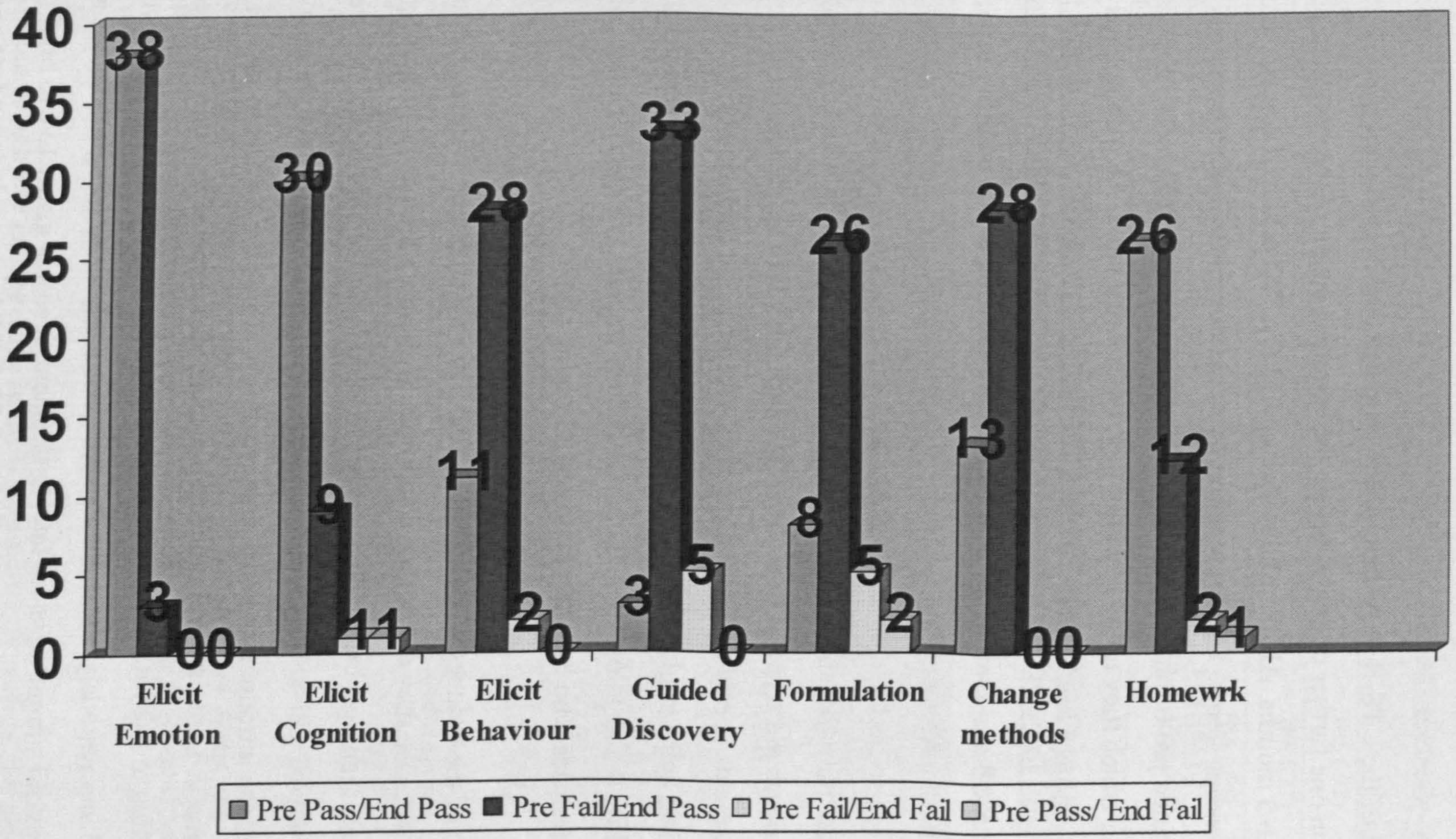
GENERAL SKILLS	Number of trainees not achieving competence	Number of trainees achieving competence	TOTAL
1. Agenda setting & adherence	5	9	14
2. Feedback	0	4	4
3. Collaboration	0	6	6
4. Pacing and effective use of time	0	2	2
5. Interpersonal effectiveness	0	1	1
TOTALS	5	22	27

Table 5.22 shows that at the end of training, the 20 trainees who had submitted pre-training tapes were mostly successful in achieving competence in the 27 general skill items that they had not achieved at mid-training assessment. The only exceptions were five trainees who did not achieve competence in Agenda setting & adherence for a second time.

5.6.4.2: Comparison of pre-training and end of training assessment of Specific CBT skills:

Figure 5.1 shows that most trainees who submitted pre-training tapes achieved competence in 3 of the 7 Specific CBT skills at that stage: though less decisively than in the assessment of General Therapy skills. 38 of the 41 achieved competence in Eliciting emotions, 30 in Eliciting key cognitions and 26 in Setting Homework. The relatively high numbers for achieving competence in these skills can be contrasted with much lower number for the other skills, 3 of the 41 in Guided Discovery, 10 in Conceptual Integration (Formulation), 11 in Eliciting Behaviour and 13 in the Application of Change methods. The large majority of the trainees who did not achieve competence in these skills at pre-training had, however, achieved it by end of training: (33 in Guided Discovery and in the Application of Change Methods, 26 in Conceptual Integration, 28 in Eliciting behaviour). These figures once again underline the steady growth of competence in skills over the period of training for the large majority of trainees. They also show a small number of trainees had not yet achieved competence by the end of training and so therefore had to make resubmissions.

Figure 5.1: Specific CBT skill results at Pre-training and end of training (n=41)



5.6.5: End of training assessment of trainees submitting pre-training tapes:

At the end of the training period, 17 of the 41 trainees still had 1 or more outstanding items: 9 had just 1 item, 5 had 2, 1 had 3, 1 had 4 and finally 1 had 7) 33 CB skills items - General Therapy and Specific CBT - in all) from the general and/or specific skills of the CTS-R to resubmit. The training course regulations allowed them to do this on one further occasion before the commencement of the next training year, i.e., within 3 months. All 17 resubmitted and 13 (76.7%) achieved competence in all outstanding items. The 4 remaining trainees (along with 2 others who had not submitted pre-training tapes) had to re-register for further Semesters of training, during which they could resubmit their assessment tapes. All 4 completed this task successfully.

5.6.6: Skill assessment for trainees not submitting a pre-training tape:

14 other trainees entered the study without submitting a pre-training tape. Results reported so far have excluded those for these trainees as the presentation of results because they have been focused on comparing pre-training with later results. As these 14 trainees did respond to requests to return the CBTTQ, the results of their skill assessments at mid and end of training were included in the study. The inclusion of this data helps to give the fullest possible picture of trainee skill performance during training. It also allows us to consider if these trainees were performing differently than trainees who had submitted a pre-training tape.

Some of the trainees who did not submit a pre-training tape were unable to submit tapes because they did not have appropriate clients, adequate recording equipment or because their agencies had not agreed to them taping clients as yet. One trainee had been unwell and another had made a very late decision to join the training and had missed the introductory pre-course meeting at which the request to submit tapes had been made. Later, several trainees, however, also reported that they had been unwilling to submit their work for scrutiny at that stage. Although tapes would be stored anonymously, the trainee's voice was likely to be recognisable. As all these 14 trainees did submit tapes for later assessment, it seems instructive to brief indicate how they fared in their results. Tables 5.23 & 5.24 present Independent samples t-test analysis comparing mean performance results of this group with the previous results presented for the group of trainees who did submit pre-training tape.

Table 5.23: Comparison of trainees submitting and not submitting pre-training tapes: Mean (&SD) competence rates at mid-training assessment of General Therapy skills with independent t-test analysis:

	Trainees who had submitted pre-training tapes (n=41)	Trainees who had not submitted pre-training tapes (n=14)	T-values for df=53 (Significance)
1. Agenda setting	0.66	0.64	T= .105 (.92)
2. Feedback	0.90	0.93	t=- .288 (.77)
3. Collaboration	0.85	0.84	t= 584 (.56)
4. Pacing	0.95	0.86	t= 1.163 (.25)
5. Interpersonal Effectiveness	0.98	0.86	t= 1.699(.095)

Table 5.24: Comparison of trainees submitting and not submitting pre-training tapes: Mean (&SD) competence rates at end-of-training assessment of Specific CBT skills with independent t-test analysis:

	Trainees who had submitted pre-training tapes (n=41)	Trainees who had not submitted pre-training tapes (n=14)	T-values for df=53 (Significance)
1. Eliciting emotion	1.00	1.00	-
2. Eliciting cognition	0.95	1.00	t= -.832(.41)
3. Eliciting behaviour	0.80	0.79	t= .152 (.98)
4. Guided Discovery	0.88	0.71	t= 1.43 (.16)
5. Formulation	0.88	0.93	t= -.90 (.37)
6. Applying change methods	0.88	1.00	t= -1.37 (.18)
7. Homework	0.93	1.00	t= -1.03 (.31)*

Table 5.23 and Table 5.24 show that there were no significantly different scores between the two groups in the assessment of either General Therapy or Specific CBT skills at mid and end of training respectively.

Though there were these differences, neither group was superior in all areas: the group that submitted pre-training tapes scoring higher in 6 of the 12 skill areas and lower in the other 5.In one area both groups scored the same.

5.6.7: Time taken to achieve competence in all General and Specific CBT skills: for all trainees:

In summary, most trainees were eventually able to achieve CBT competence using the skills assessment procedures of the CTS-R but the time periods needed to achieve this

varied between 9 months (up to the end of training period), 12 months (training period plus resubmission for final assessment) and 18 months (training period plus resubmission and a further period of training to retake modules). Table 5.25 shows the cumulative completion rate over time:

Table 5.25: Time taken to achieve CBT competence using CTS-R assessment methods:

	Number of trainees achieving competence in all CTS-R items	Cumulative percentage
Training period Sept- June (9 months)	32	58.2%
Training period + resubmission. Sept-Sept (12 months)	17	89.1%
Training period + resubmission + further module. Sept – Sept – following Feb. (18 months)	6	100.0%
TOTAL	55	100.0%

Table 5.25 shows that almost 58% of the trainees in this training programme were able to establish competence in CBT skills (as measured using the CTS-R) within the academic year in which the course ran. A further 31% of the trainees had required the cushion of a brief resubmission period to complete satisfactory competence in all the skills. This left a small group of six trainees who needed to retake various aspects of the training course again during an extra 6 month Semester before they were finally able to successfully attain competence in all the skill areas. Thus this final small group took almost twice as long as the larger group of trainees who were able to complete CBT skill acquisition within the academic year.

5.7: Research Question C: What influence does model preference play on the acquisition of competence in CBT?

The CBT skill assessment results presented in the previous section will now be re-examined and comparisons will be made between the results for trainees who began training with different therapy model preferences. Two aspects of model preference will be explored. Firstly, there is the general self-description indicating adherence to one set of therapeutic ideas or another: for example, choosing between descriptor labels such as 'Cognitive-behavioural' or 'Person-centred'. Secondly, there is a rank order of the influence of such choices. For example, a trainee might choose the overall description, 'Person-centred' but might rank CBT quite highly as an influence or quite lowly. A low ranking might indicate quite aversive responses to some CBT principles. Name descriptor choices and rank ordering of CBT were identified at pre-training questionnaire. Table 5.26 shows a cross tabulation of the two factors:

Table 5.26: Pre-training model preference and rank order of CBT

	CBT	PCT	Psychodynamic	Integrated/Eclectic	TOTAL
1st	8	1	0	2	10
2nd	0	10	1	7	19
3rd	0	6	2	3	11
4th	0	6	2	1	9
5th	0	3	2	1	6
Total	8	26	7	14	55

Table 5.27 shows how trainees of different model preferences reported the therapeutic attitudes described in Section 5.5 and how these developed over the course of training.

Table 5.27: Mean CBPI scores over the period of training by initial model preference with one-way ANOVA analysis

	Pre-training (N=55)	Post-training (N=51)	Follow-up (N=48)
Preference	Mean	Mean	Mean
CBT	34.75 (n=8, SD= 2.82)	37.00 (n=7, SD=3.46)	35.71 (n=7, SD=1.80)
PCT	28.81 (n=26, SD=4.89)	34.65 (n=23, SD=4.21)	34.59 (n=22, SD=3.57)
Psychodynamic	28.57 (n=7, SD=3.10)	34.71 (n=7, SD=3.40)	31.14 (n=7, SD=4.67)
Integrated/ Eclectic	31.79 (n=14, SD=4.26)	35.21 (n=14, SD=3.09)	35.25 (n=12, SD=2.42)
ALL	30.40 (n=55, SD=4.74)	35.14 (n=51, SD=3.70)	34.42 (n=48, SD=3.50)
ANOVA F-score, df, (sig.)	F (3,54) = 4.80 (.005)*	F (3,50)= 0.74 (.53)	F (3,47)=2.92 (.045)*

* Significance, $p < 0.05$

Multiple comparisons using the Bonferroni correction were made for all three stages. At pre-training there was a mean difference in score of 6.18 between CBT and Psychodynamic, and, 5.94 between CBT and PCT, both differences showed significance, .047 and .008 respectively, where $p < 0.05$. At end of training, the differences between mean scores for the different orientations, has narrowed and no longer shows a significant difference in the ANOVA analysis, F=.742, df= 3,50 p=.532, so that multiple comparisons are not relevant. At follow-up, the difference between mean scores of the different orientations is again significant, F=2.92, df=3, 47, p=.045, but no significant mean differences between trainees with different model preferences are reported in the SPSS output.

Trainees were also asked to rank order their therapy model preferences from a range of models at pre-and post-training and then again at follow-up. The rank order ascribed to CBT is shown in Table 5.28:

Table 5.28: Rank assigned to CBT in ranking of models (Pre, Post & Follow-up)

	Pre-training	End of training	Follow-up
First	10	17	16
Second	19	25	25
Third	11	6	5
Fourth	9	3	2
Fifth	6	0	0
TOTAL	55	51	48

The ten trainees nominating CBT as their first ranking influence at pre-training included eight who had named CBT as their first preferred model and two who had named integrated/eclectic therapy as their preferred model but nominated CBT as their first ranking influence. The rank ascribed to CBT shows modest progress over the period of training and follow-up: the number of trainees nominating CBT as either their first or second main influence increased from 29 of 55 trainees at pre-training to 41 of 48 at follow-up. Table 5.28 shows that for most trainees there was a general movement of preference towards assigning a higher rank towards CBT during and after training.

Table 5.27 showed that increases in adherence to CBT principles were evident across all pre-training model preferences that trainees held prior to training. Table 5.28 showed that CBT moved to higher ranks on the rank order of preferred models of

therapy, so that at follow-up 85% of respondents gave CBT 1st or 2nd rank, compared to 53% at pre-training..

5.7.1: Trainee competence shown by the assessment of individual CB skill items by orientation preference at pre-training:

Table 5.29 reports trainee performance on all individual CB skill items at all stages by pre-training orientation preference indicated by selection of a therapy name descriptor. As previously, performance is described by mean competence rates where scores close to 1.0 imply very high competence rates and scores close to 0.0 imply very low competence rates.

Table 5.29 to 5.31 show that there are some differences in the achievement of competence in CBT skills between trainees initially preferring different models at different stages of training

Table 5.29: Performance in individual CB skills items by pre-training model preference at pre-training assessment:

PRE-TRAINING (n=41)	CBT (n=8)	PCT (n=18)	Psychodynamic (=5)	Integrated/ Eclectic (N=10)	All (n=41)	One way ANOVA F-ratio	Degrees of freedom, Significance
1. Agenda setting & adherence	0.75	0.22	0.00	0.30	0.32	3.98	(3, 37) .02*
2. Feedback	0.25	0.33	0.40	0.10	0.27	0.73	(3, 37) .52
3. Collaboration	0.75	0.94	1.00	1.00	0.93	1.70	(3, 37) .19
4. Pacing & efficient use of time	1.00	0.33	0.40	0.70	0.56	4.73	(3, 37) .01*
5. Interpersonal effectiveness	1.00	1.00	1.00	1.00	1.00	-	-
6. Eliciting emotion	0.88	0.89	1.00	1.00	0.93	0.59	(3, 37) .62
7. Eliciting key cognitions	1.00	0.67	0.40	0.90	0.76	2.95	(3, 37) .05*
8. Eliciting behaviours	0.88	0.00	0.40	0.20	0.27	14.68	(3, 37) .00011*
9. Socratic Questioning	0.25	0.00	0.20	0.00	0.07	2.58	(3, 37) .07
10. Formulation	0.13	0.22	0.40	0.30	0.24	0.47	(3, 37) .71
11. Application of change methods	0.88	0.11	0.20	0.30	0.32	7.39	(3, 37) .001*
12. Setting homework	1.00	0.44	0.60	0.80	0.66	3.36	(3, 37) .03*

* = Significant, $p < 0.05$

Table 5.29 shows that in the pre-training assessment, differences are big enough to attain significance, $p < 0.05$, in the General Therapy skills of Agenda setting & adherence, and, Pacing & efficient use of time. Differences also attain significance in the Specific CBT skills of Eliciting key cognitions, Eliciting behaviours, Applying

change methods and Setting homework. Post-hoc pair-wise analysis showed that there were significant differences between CBT and PCT at the pre-training stage in the skills of Agenda setting & adherence, Pacing & efficient use of time, Eliciting behaviours, and, Setting homework. It also shows that there were significant differences between CBT & Psychodynamic and CBT & Integrated/Eclectic in pre-training performance in Eliciting behaviours and Applying change methods at pre-training.

Table 5.30: Mid-training assessment by initial model preference (n=55)

MID-TRAINING (n=55)	CBT (n=8)	PCT (n=26)	Psychodynamic (=7)	Integrated/ Eclectic (N=14)	All (n=55)	One way ANOVA F-ratio	Degrees of freedom, Significance
1. Agenda setting & adherence	1.00	0.42	0.71	0.86	0.65	5.28	(3, 51), .003*
2. Feedback	1.00	0.81	1.00	1.00	0.91	2.13	(3, 51), .11
3. Collaboration	0.88	0.77	1.00	0.86	0.84	0.76	(3, 51), .52
4. Pacing & efficient use of time	1.00	0.85	1.00	1.00	0.93	1.63	(3, 51), .19
5. Interpersonal effectiveness	1.00	0.92	1.00	0.93	0.95	0.38	(3, 51), .77

* = Significant, $p < 0.05$

Table 5.30 shows that at the mid-training stage, there was still a significant difference in the performance of Agenda setting & adherence. Post-hoc pair-wise analysis showed that this difference was between CBT & PCT and Integrated/Eclectic & PCT.

Tale 5.31: End of training assessment by initial model preference: (n=55)

END OF TRAINING (n=55)	CBT (n=8)	PCT (n=26)	Psychodynamic (=7)	Integrated/ Eclectic (N=14)	All (n=55)	One way ANOVA F-ratio	Degrees of freedom, Significance
1. Eliciting emotion	0.88	0.96	1.00	0.86	0.93	0.76	(3, 51), .52
2. Eliciting cognitions	1.00	0.92	1.00	1.00	0.85	0.75	(3, 51) .53
3. Eliciting behaviours	1.00	0.69	0.86	0.86	0.80	1.45	(3, 51) .24
4. Guided discovery	1.00	0.81	0.86	0.86	0.84	0.92	(3, 51), .60
5. Formulation	0.88	0.81	0.86	0.93	0.85	0.35	(3, 51), .79
6. Apply change methods	1.00	0.88	1.00	0.86	0.91	0.69	(3, 51) .56
7. Homework	1.00	0.88	1.00	1.00	0.95	1.17	(3, 51), .33

Table 5.31 shows that at the end of training, there were no significant differences in Specific CBT skills performances between trainees from difference modality preference groups. In general, rates of achieving competence were high in most areas once training is underway so that significant differences are not evident at end of

training: though certain areas showed lesser gains – especially Agenda-setting, Eliciting behaviours and Conceptual Integration (Formulation). PCT trainees, however, tend to perform somewhat less well in most CB skill areas at all stages of training and this trend was more noticeable in the slower developing skills of agenda-setting, eliciting behaviours and formulation.

After the end of training trainees were given one final chance to achieve competence in skills that they had not as yet demonstrated before the commencement of the following academic year. The numbers involved are too small to analyse by ANOVA analysis. As reported in 5.7 all but six trainees passed their outstanding skill assessment in final assessment. Some details of these six trainees, who all elected to take extra module teaching in the following academic year are shown in Figure 5.2:

Figure 5.2:Trainees with outstanding skill assessment items at the end of training

Trainee:	Preference:	Skill items outstanding:
A:	PCT	Agenda-setting; Eliciting behaviours; Guided Discovery.
B:	PCT	Agenda-setting; Guided Discovery.
C:	PCT	Eliciting behaviours.
D:	PCT	Eliciting cognitions.
E:	Psychodynamic	Agenda-setting; Guided Discovery.
F:	Integrated/Eclectic	Eliciting behaviours.

All these trainees did enrol for further Semesters of study and did manage to achieve all CBT skills in their further periods of study. It can be seen that some in the group of trainees who began with a PCT background generally did less well than those with other modality preferences. Most, however, did achieve competence within the academic year of the course but a small number continued to struggle with certain competencies and this led them to pursue further periods of training, thus taking longer to achieve competence in all the skills measured by the CTS-R.

5.7.2: Time taken to achieve CBT competence on all assessment items by orientation:

The previous section showed that all the trainees who entered this study were eventually assessed as having achieved CBT competence in using both the General Therapy and Specific CBT items in the CTS-R. Some trainees, however, took nearly

twice as long to achieve this result than others. Table 5.25 laid out the relevant time period and the number of trainees achieving CBT competence during them. These time periods will now be reconsidered from the perspective of the orientation background of the trainees completing during them and reported in Table 5.32:

Table 5.32: Time taken to meet CBT assessment criteria by stated orientations at pre-training (n=55):

	9 months	12 months	18 months	Mean completion time (SD)
CBT	7	1	0	9.38 (1.06)
PCT	12	10	4	11.54 (3.14)
Psychodynamic	5	1	1	10.71 (3.40)
Integrative/Eclectic	8	5	1	10.71 (2.56)
Total	30	19	6	10.91 (2.85)

Table 5.32 shows that just over half the trainees achieve competence in all the CTS-R assessment items by the end of nine months of training. Trainees with a PCT first therapy model preference have a notably lower completion rate by this stage. Most trainees are able to quickly resubmit and achieve all items within a further three months, bringing the overall competence rate up to nearly 90%. A small group of trainees, within whom those with a PCT background are somewhat over-represented, need a further extension of learning but are able to achieve competence in all skill items by the end of that time. One-way ANOVA analysis of the differences between mean completion times for trainees with different modality preferences, however, is not significant, giving an F-score of 1.25, $p > 0.05$.

Summary of the CBT skills performances of different trainee groups by name descriptor model choice:

There are consistent differences between the performance of trainees choosing different model name descriptors and these achieve significance between particular modalities, especially between CBT and PCT, at particular times, especially at pre-training assessment, and in the assessment of particular skills, especially agenda-setting & adherence. Other differences between modalities are sometimes evident but these differences do not reach significance in ANOVA analysis due to the low number of participants in the study leading to the results being under powered.

5.7.3: Rank order of model preference and assessment performance

Trainees were asked to indicate model preferences before they began training in CBT and they were also asked to indicate where they would rank CBT amongst the plurality of models that were likely to influence them. It was theorised that this could be important in that some trainees might indicate a PCT preference, for example, but rank CBT as the second highest ranking influence on their practice. By contrast another trainee might report a PCT preference but rank CBT only 4th or 5th as an influence on her practice. It was hypothesised that these two types of trainees response might be differently reflected in trainee skill performance.

Analysis here will present assessment results at various stages of assessment by rank ordering of the influence of the CBT model at pre-training. Rank orders were taken only in the pre-training administration of the CTTQ questionnaire. Table 5.33 to 5.35 show cross tabulation of rank order of model preferences and skill outcomes and the matching analysis of this relationship using Spearman's-rho analysis of mean competence rates at the different stages of assessment by rank order of Preference for CBT at pre-training:

Table 5.33: Cross-tabulation of rank order of CBT at pre-training and mean skill competence rates at pre-training, with Spearman's rho analysis:

	First	Second	Third	Fourth	Fifth	Correlation coefficient (Spearman's rho)	Sig. (2 tailed).
Agenda	0.60	0.38	0.14	0.17	0.0	- .43*	.01
Feedback	0.20	0.38	0.14	0.0	0.67	.04	.79
Collaboration	0.70	1.00	1.00	1.00	1.00	- 38*	.02
Pacing	0.90	0.54	0.43	0.16	0.67	-.36*	.02
Interpersonal effectiveness	1.00	1.00	1.00	1.00	1.00	-	-
Elicit emotion	0.90	0.92	0.86	1.00	1.00	.11	.49
Elicit cognition	0.90	0.85	0.57	0.67	0.60	-.27	.08
Elicit behaviour	0.60	0.77	0.00	0.00	0.40	-.33*	.04
Guided discovery	0.20	0.00	0.14	0.00	0.00	- .20	.20
Formulation	0.30	0.15	0.57	0.00	0.20	- .06	.70
Apply change methods	0.60	0.31	0.14	0.17	0.20	- .33*	.03
Homework	0.80	0.85	0.43	0.17	0.20	- .29	.06

Significance, p < 0.05 level (two-tailed)

Table 5.33 shows that there are associations between rank order of CBT preference at pre-training and skill competence in 5 of the 12 skills: Agenda setting, Collaboration, Pacing, Guided Discovery, Eliciting behaviour and Applying change methods. All these associations are in the direction of the trainees reporting a higher rank of preference for CBT at pre-training tended to be more likely to attain competence: with the exception the skill of Collaboration, where the reverse was the case.

Table 5.34: Cross-tabulation of rank order of CBT at pre-training and mean skill competence rates at mid-training, with Spearman's rho analysis:

	First	Second	Third	Fourth	Fifth	Correlation coefficient (Spearman's rho)	Sig.
Agenda	0.90	0.84	0.64	0.44	0.50	- .29*	.03
Feedback	1.00	0.84	0.82	1.00	1.00	.04	.77
Collaboration	0.90	0.95	0.73	0.78	0.67	- .24	.08
Pacing	1.00	1.00	0.91	0.89	0.67	- .33*	.01
Interpersonal effectiveness	1.00	1.00	1.00	1.00	0.67	- .29	.03

Significance, p < 0.05 level (two-tailed)

Table 5.34 shows that there are associations between rank order preference for CBT at pre-training and skill competence at mid-training in the skills of Agenda setting, Pacing and Interpersonal effectiveness. All the associations are in the direction showing that trainees who reported a higher preference ranking for CBT at pre-training tended to be more likely to attain competence in those skill areas.

Table 5.35: End of training results by rank order CBT at pre-training

	First	Second	Third	Fourth	Fifth	Correlation coefficient (Spearman's rho)	Sig.
Elicit emotion	1.00	1.00	1.00	1.00	1.00	-	-
Elicit cognition	1.00	0.95	1.00	0.89	1.00	- .06	.68
Elicit behaviour	0.80	0.79	0.82	0.78	0.83	.01	.92
Guided discovery	0.90	0.84	0.73	0.78	1.00	- .03	.84
Formulation	0.90	0.89	0.82	0.67	1.00	- .09	.52
Apply change methods	1.00	0.84	1.00	0.89	0.83	- .07	.60
Homework	1.00	0.95	0.91	0.89	1.00	- .08	.55

Table 5.35 shows that there are no significant associations between rank order preference for CBT at pre-training and the attainment of competence in Specific CBT skills at the end of training. Such rank order effects for these skills at pre-training are no longer evident at the end of training.

The results reported above for associations of rank order preference for CBT and subsequent competence attainment show that there are some consistent differences in skill performance by rank ordering of the CBT model at pre-training and that some of these persist at mid-training. Generally, those ranking the model higher perform better than those ranking the model lower, especially those ranking CBT in the very lowest ranks. By the end of training, however, the positive relationship between giving CBT a high initial ranking and being more likely to achieve CBT skill competencies is no longer evident.

5.7.4: Summary of the analysis of differences in CBT skills performance by model preference and ranking:

The analysis for research question C shows that there are some differences between the performance of trainees distinguished by different model choices and ranking of preference for CBT at pre-training. These differences are shown in pre-training assessment of the following skill items:

Agenda setting & adherence:	Model preference & rank order preference for CBT
Collaboration:	Model preference & rank order preference for CBT (reverse)
Pacing & efficient use of time,	Model preference & rank order preference for CBT
Eliciting cognitions:	Model preference only.
Eliciting behaviours,	Model preference & rank order preference for CBT
Application of change methods	Model preference & rank order preference for CBT
Setting homework.	Model preference only.

Where pair-wise comparisons were made they tended to show that in the case of model preference, trainees preferring CBT tended to perform significantly better than others, especially PCT trainees, in some areas.

As training proceeds, these differences become less pronounced, and no longer show significant differences, with the exception of mid-training assessment of:

Agenda setting:	Model preference & rank order preference for CBT
Pacing and efficient use of time:	Rank order preference for CBT only.
Interpersonal effectiveness:	Rank order preference for CBT only.

As at pre-training, however, though most PCT trainees are attaining competence, some of them continue to do less well, especially when compared to CBT trainees. A small number of trainees, often of the PCT preference, continue to show difficulty with

achieving competence in Agenda setting & adherence even at the end of the designated training period of one academic year. They subsequently have to retake certain assessments and this delays their final attainment of CBT competence, as assessed by the CTS-R. As was shown earlier, PCT and Psychodynamic trainees tended to accord CBT a lower ranking as a pre-training influence. The analysis of the skill assessment performance of trainees, who ranked CBT in the lowest ranks, showed that they performed less well but this was more evident for PCT trainees. Although it was only a minority of PCT trainees that showed more problems attaining competence after the start of training, this minority appears to be over-represented in the group that began CBT training, not only by holding a preference for a non-CBT model, but also by allocating a low rank for CBT in their rank order of therapy model influences

5.8: Summary and Conclusion to Chapter 5:

The study followed three cohorts of trainees with backgrounds in employment and training in counselling who undertook specialist training in CBT. The trainee cohorts were equivalent in most of the characteristics surveyed. Women formed around 80% of the final sample of trainees. Trainees were mature students with an average age of around 46 years. They came from a variety of educational and employment background, were mostly counsellors, and were evenly split between graduates and non-graduates. They were mostly looking to move into more counselling orientated or more specialist counselling work. Though some had the backing of employers, few enjoyed much practical support over issues such as paying fees and arranging time off to attend training. Very few employers were reported as regarding training that was specifically in CBT as a priority.

Before training, the trainees in general showed quite high levels of agreement with most CBT principles, though they also held reservations about some of these principles, especially those that concerned structuring therapy and aiming to keep therapy time-limited. Almost half the trainees declared a preference for the Person-centred model of therapy, with the others divided between preferences for the CBT, Psychodynamic and Integrated/eclectic therapy models. Even when indicating a preference for another model,

21 trainees with preferences for another model ranked CBT first or second in their rank order of therapy model influences. Twenty six trainees, however, preferred a non-CBT model and allocated CBT 3rd, 4th or 5th rank in order of influence. Over the period of training in CBT, most trainees increased their level of agreement with CBT principles and either declared CBT as their new main influence or moved CBT to a higher rank in their orders of therapy model influence. The attitude changes were significant at the post-training phase and were largely maintained at one year follow-up so that the change from pre-training attitudes to follow-up attitudes was also statistically significant.

In pre-training CBT skills assessment, most trainees showed some pre-existing ability to perform some of the skills of CBT, especially those most strongly related to general therapy skills, such as Interpersonal effectiveness and Eliciting emotions. Competence rates for most skills showed significant increases at mid-training and end-of-training assessment. A small minority of trainees continued to have problems mastering CBT skills and some had to take additional modules of instruction. All these trainees did eventually achieve competence in all items, but some of them had taken twice as long to achieve this as trainees who had already achieved competence in all skill areas at end-of-training assessment.

Performance in CBT skill assessments was examined by initial identification of orientation and by rank order of CBT in model preferences. Trainees with a stated CBT, Psychodynamic and an Integrative/Eclectic therapy orientation generally performed better than trainees with a Person-centred orientation, though these differences only achieved significance in ANOVA analysis for some skill areas at some stages. Person-centred trainees tended to have specific problems with such areas as structuring the therapy and Agenda setting & adherence. Given the initial observation that structuring seemed a consistent problem for a minority of trainees and the reported reservations held by person-centred therapists on structuring, such a skill result was hypothesised as likely. On the other hand, psychodynamic orientated therapists also report this reservation and yet trainees with initial psychodynamic preference did not show such difficulty with structuring in assessments. These problems tended to persist in a minority of PCT

trainees, causing them to have to resubmit assessments and/or retake learning modules and thus to take longer to achieve success in all CBT skill areas. The higher the rank order which trainees ascribed to CBT at pre-training, the more they were likely to achieve better rates of competence in at least some CB skill assessment areas at the pre-training and mid-training assessment stages. Differences between modality and rank order preferences were less pronounced at the end of training and did not reach significance for any skill or skill area.

Overall, the influence of model preference and model ranking was consistent: e.g., trainees with a PCT orientation performed less well in many CB skill areas, especially at pre- and mid-training – when 11 failed agenda setting, but these trends were not consistently strong enough to achieve statistical significance across the board. Analysis of rank order preferences indicated that there is a group of trainees with non-CBT model preferences and a tendency to rank CBT lowly as a model of influence and that they tend to attain significantly lower rates for achieving competence in CBT skills assessments and are slower to attain overall competence.

Attitudes in the study were tested at pre-training, end of training and one year follow-up. Skills were tested at pre-training, mid-training, end of training and final assessment. Differences in attitudes were associated with some differences of performance of some skills at the pre-training stage. Both attitudes and skills changed as training progressed. Positive changes in attitude were significant at the end of training and at follow up. Positive changes in skill acquisition also progressed as training progressed. Some significant differences in skill performance between trainees from different orientations were still evident at mid-training but not by end of training. These facts imply that factors connected with the training period may have been able to deal with attitudinal reservations about the model in a way that facilitated skill learning but results examined thus far do not tell us much about how and when this was achieved. The next chapter presents analysis of the interviews with 24 trainees in the follow-up period. The interviews throw some further light on some of the issues analysed in this chapter. Additionally, they present more reflective data on the trainees' experiences of training:

what they found helpful, what they found difficult and how they overcame difficulties in training. The chapter therefore presents data that relates to the final research question, D, of the study that seeks to explore what ways trainees report surmounting difficulties learning CBT.

Chapter 6: Trainee Perceptions of the CBT Training Process

Introduction

This chapter presents analysis of data collected during semi-structured interviews with trainees one year after the end of training. The interview schedule asked trainees to reflect on their experiences prior to, during and after training. The analysis distinguishes between the answers of trainees from the 4 different orientation preferences at each of these 3 different stages and consolidates responses into 12 thematic charts, presented throughout the chapter close to sections in which they are discussed. Data in the charts consists of various category headings followed by representative brief quotations from the interviews. The quotations, categories and themes are further elaborated in the text of the chapter. Iterative category development and refinement of categories emerging from the charts culminates in the construction of a Central Thematic Chart (Ritchie & Lewis, 2003) located towards the end of the chapter. Discussion of associations and linkages evident in the whole process of analysis takes place mainly in Chapter 7 so that discussion of the interview data may run in parallel with consideration of the quantitative data at the many points where they overlap.

Presentation of data from the interviews will be in three parts. Firstly, there will be analysis of the data in relation to responses to the questions of Section A of the interview schedule, covering pre-training factors. This will be followed by analysis of data from Sections B, on experiences of training, and then, Section C, on how trainees have developed since CBT training. Particular focus will be devoted to tracing the thinking processes of trainees as they adapt to the challenges of CBT training.

Each quotation has an identifying tag, including an identifier of the gender of the respondent. A full explanation of the identifying tag is given with the first quotation on the next page. There are 5 interviewees who began training with a CBT preference, 2 of whom are males. There are 13 interviewees who began with a PCT preference, 1 of whom is male. There are 3 interviewees, all female, who began with a psychodynamic preference. Similarly, there are 3 interviewees, all female, who began with an Integrated/Eclectic preference.

6.1: The pre-training stage (Section A of the interview schedule):

Categories in the thematic charts were developed in an iterative process throughout analysis. The iterative process involved consultation with a group of colleagues and former trainees who read interviews, examined categories and made suggestions resulting in refinements of categories. The main categories that arose in relation to the pre-training phase concerned how trainees' thinking about undertaking CBT training developed:

* What range of ideas did trainees' knowledge of CBT come from?
* How CBT seemed to sit within that range of knowledge and with their current ideas about therapy
* How the training would fit with their ideas about how their careers might develop
* How they considered that their employment situation might change as a result of CBT training.

6.1.1: *Trainees with CBT model preference at pre-training:*

Trainees who began training with a model preference for CBT divided between finding their first impetus to take up CBT in either a training experience:

> In the Diploma year, we did cognitive therapy (and)... I immediately realised that it was the theoretical approach for me... I have always gone about life addressing my thinking and questioning myself in a rational way. **(476/F/A1/CBT[1])**

or in experience as a therapist:

> I first got interested when I worked as a social worker... in a behavioural unit... There was a psychologist there who was a behaviourist... I got some training... and got introduced to Beck's work during some training at Goldsmith's **(597/M/A1/CBT).**

They often recall an immediate sense of personal appeal when they had first heard about CBT:

> I do think that CBT fits with my personality because ... I believe that I am a pretty direct person **(342/F/A1/CBT).**

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[1] The first number refers to the respondent number, the following letter tag refers to gender, the second number to the interview question location of the quotation and third (letter) tag to the orientation of the interviewee: In this case, Respondent 342, who was female and reported an initial CBT preference, is answering question A1 of the interview schedule.

Unlike trainees who began with preferences for models other than CBT, these trainees had no reservations about how their existing ideas might fit with what they were about to learn. They had very positive views of CBT and made strong estimates of the effectiveness of CBT. When asked how effective CBT was, a typical response was:

> On a scale of 0 to 10, I would say a 9. **(476/F/A4/CBT)**

These trainees tended to have rejected other models:

> Person-centred stuff all seemed so dreary and vague … and psychodynamic theory was difficult to grasp **(342/F/A2/CBT)**
>
> I did not like the Rogers stuff much… it was very much like what I don't want to be like **(358/M/A2/CBT).**

They felt that they already had quite a good grasp of CBT and that this knowledge would fit well with training. This understanding could be refined or extended by further training and professionalism:

> I thought that the training would be an extension: more of the same, refining it, understanding it better and becoming a better practitioner **(358/M/A5/CBT).**

They tended to stress career motivation and sometimes reflected relatively pragmatic choices:

> I wanted to become a proficient practitioner… I wanted to specialise but the counselling psychology course was very, very general … the way I looked at it, was that if I can get the CBT qualification, I can offset a lot of requirements for counselling psychology… not kill two birds with one stone exactly but satisfy my need for training in CBT and move towards my ultimate aim – chartered status. **(471/F/A6/CBT).**

Like almost all trainees in the study, these trainees expressed fears about failing the training course but also stressed a strong motivation to develop a recognised professional competence:

> I hoped that I'd become competent at CBT… be able to implement it more thoroughly … be a professional … I feared that I wouldn't complete the course … **(342/F/A7/CBT).**
>
> I hoped that the reputation of the course and of CBT would help me to become a professional therapist rather than just a counsellor **(346/F/A6/CBT).**

In some respects, the CBT oriented trainees showed a more pragmatic attitude to the practical concerns of training than other trainees:

> I was about to do a course in the Midlands and then I realised that there was a more local one **(471/A5/F/CBT).**

Unlike other trainees, these trainees were self-employed and so did not have relevant comments on employer support of training. They tended to have reached their current position by quite idiosyncratic routes:

> I had a pension from the Police and I did other courses to be able to get some more money and pay my way through **(358/M/A8/CBT).**

In summary, the trainees with a preference for CBT entered the training with naturally positive expectancies about what they would learn and how it would fit into their current practice. These trainees were often in transition from independent to paid employment and perhaps had most to gain from allying themselves to a rising paradigm like CBT. They were aware of competition for therapy jobs and seemed to bank on the CBT training and the Masters degree helping them to secure other employment. They stressed more pragmatic and career orientated motivations for doing the training than some other trainees.

6.1.2: *Trainees with PCT model preference at pre-training:*

PCT trainees mostly came to hear about CBT in their initial counselling training:

> I only really heard about CBT as such during the Diploma course. One of the tutors was CBT and did a demo session. I could see it in action and saw that it worked **(347/F/A1/PCT)**[2].

Or during the experience of doing therapy:

> I started working as a student counsellor... I used the person-centred approach and I became more and more dissatisfied with what I could offer students... I wanted something that felt a little more practical, I guess **(472/F/A1-4/PCT).**

> I was having to do more short term work in my job and then, during the Diploma course, I started talking to another student who was into CBT, doing shorter term work and I was impressed by what she was saying **(469/F/A1/PCT).**

During initial training, they reported being introduced to the different models of therapy, some of which were congenial whilst others were rejected:

> I never rejected the person-centred model but I did reject the psychodynamic theory. Something happened in College but I was already very, very doubtful... The (psychodynamic) tutor has said that there is always a hidden agenda... (In one group) we were discussing a case where the client had 11 siblings and the tutor said, 'There is something you've all missed.

> How many of us are there in this group? There are eleven!'... Most of us just looked at our boots. ... We all sat there feeling about 3 years old **(345/F/A4/PCT).**
>
> In the Diploma course, we did little sections on psychodynamic and then cognitive... when we did psychodynamic I thought I've never heard so much rubbish...cognitive (in) comparison... felt right for me... more scientific... not airy fairy, wishy-washy **(349/A1/PCT).**

When introduced to the PCT model, trainees often reported an instant personal appeal:

> The Certificate year for me was falling in love with Carl Rogers **(345/F/A1/PCT)**

As time went on, however, some began to identify limitations of the PCT approach. These limitations were mainly practical so that trainees tended to hang on to Rogerian values, whilst at the same time look for "more effective" practice:

> To me, person-centred was effective because it chimed in with my values... but there was also a kind of doubt...I'd hit a stop - kind of 'well we understand that but now what?' I did have mixed feelings about CBT but had more concern about being effective for my clients **(343/F/A4-5/PCT).**
>
> I had a very strong belief in person-centred to begin with but the doubts came in... (Especially) in relation to short term work... So I stayed with PCT but hoped that I could find other things to integrate with it, to make it work better **(469/F/A4-5/PCT).**

When these PCT oriented trainees encountered CBT, however, some of them reported a sense of personal pull similar to that reported by the trainees preferring CBT:

> I started using a layman's version of CBT... I liked the values of person-centred but I had a few doubts about its effectiveness. I was unsure about training in CBT but got more optimistic as it got closer **(347/F/A4/PCT).**
>
> I felt that I was more directive than other people (in the PCT training group). It wasn't enough Carl Rogers[3]. I thought that I could integrate CBT and that they would fit quite well **(468/F/A4-5/PCT).**

PCT trainees showed a strong attachment to Rogerian values though a lesser attachment to PCT practice. The non-directive principle is a strong aspect of PCT values. PCT trainees, along with psychodynamic trainees, often had entertained overt or covert reservations about how learning CBT would fit with the values of their current style of practice.

> There was some fear that I was moving away from the person-centred model, having to be structured and set an agenda and all that raised anxieties... you're not just sitting down and saying, 'Tell me your story.' You know, 'homework', how was I going to ask my client that? That was quite a drift from person-centred work. Would I be able to hold onto my person-centred values? **(477/F/A7/PCT)**

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[3] This trainee was a French-speaking Vietnamese woman with a Welsh husband. This statement means 'The Rogerian approach was not enough for effective therapy!'

We may also notice that as they reflect on those attitudes now at the research interview, the way PCT attitudes subsequently developed sometimes becomes apparent:

> I am more of a goal-orientated person... I was worried that CBT was controlling and I struggled with that. I talked it over with one of the tutors and she said, 'Are you getting confused between directive and controlling?' .... I thought, 'Hang on; I *am* confusing direction with controlling' **(347/F/A3-5/PCT).**

> I think that it was first and foremost that CBT fitted my personality... Compared to Rogers it is more directive... but it isn't saying that you have to go in there with hobnail boots on. ... Not overly directive - and that is nice... (When I did PCT) I tended to explore too many things and I'd end up not getting anything done **(351/F/A5-6/PCT).**

They were sometimes aware of CBT becoming more talked about in the professional or wider community:

> CBT had been in the media... Anthony Clare's radio programme and it just seemed to make sense. The qualification wasn't the priority for me; I wanted to be an effective practitioner **(356/F/A6/PCT).**

This group of trainees often did have reservations about CBT, but training in it also seemed to offer potential gains:

> I was relatively late back into education and it was a way of developing me: it was a dream, to be honest, to go to a university and have the chance for a higher degree and maybe get some work out of it too. Wow, nice one! ... The hope was always to finish the course and get the qualification **(346/F/A6-7/PCT).**

> I wanted to achieve competence in CBT... I wanted to know the underlying theory... not a 6-week effort; you know. If you haven't got the tools and knowledge behind you to do that, then that makes you a bad practitioner **(351/F/A7/PCT).**

Gains, however, frequently involved the risk of failure:

> The main fears were all academic. I was afraid to apply, I didn't even think that I'd get on the course, never mind pass it **(347/F/A7/PCT).**

> I never thought that I'd actually fail but I feared that I wouldn't be able to do it well and that would have felt like the waste of a couple of years effort **(353/F/A7/PCT).**

Other fears included the loss of previously hard won competence in a more reflective style of counselling:

> I never feared that I might lose the relationship in CBT as many of the other person-centred inclined people did but I worried that the relationship might change in a way that I didn't really feel comfortable with, you know, like you could become a CBT automaton! **(472/F/A7/PCT)**

> I did wonder if CBT was a bit cold and impersonal but I hoped that they could be integrated **(595/M/A5/PCT).**

In contrast to the CBT trainees, most of the PCT trainees worked in organisations and had employers. Some of organisations showed some hostility to CBT:

> Quite a few people in [the agency] were person-centred and very anti-CBT… They knew that I was doing CBT but it wasn't something to discuss very much! **(477/FA8/PCT/VOLUNTARY SECTOR[4])**

Employers were only very rarely interested in the fact that their employees were being trained in CBT. If there was support, it was mainly personal support:

> Oh well, it was just a case of signing the CPD form, no real interest after that… My team leader took an interest, but that was kind of personal support more than professional support **(353/A8/PCT/PSYCHOLOGIST).**

Support and recognition of a more material kind were very limited:

> My employers thought that I'd done enough training by the time I'd completed the Counselling Diploma. They weren't particularly interested in CBT and certainly not into giving me any money **(345/A8/PCT/YOUTH WORK).**

> My employers did give me money to do the course – after a fight! – But there wasn't much interest in what exactly I was doing or in CBT as such. **(472/A8/PCT/STUDENT COUNSELLOR)**

In summary, PCT trainees entered CBT training with a mixture of hopes that training could make their practice more effective, and, fears that CBT could prove both inimical to their person-centred values and difficult to learn. Some began to recognise, however, that as well as a respect for person-centred values, they also leaned towards a more goal–oriented approach, as is stressed in CBT. Perhaps trainees attracted to goal-direction held the PCT position in a slightly more pragmatic way so that they had already begun to incorporate some CBT methods, such as thought records, even before CBT training (349/A3). Others, perhaps adhering to the more ideological version of PCT, feared that learning a structured therapy might lead them to lose their non-directive values and thus leave them in a kind of no-man's land - neither one thing nor the other. They could, however, see the possibility that some kind of integration of past and future practice might be possible - "A way of working with people on change without losing a person-centred sense of warmth," as Respondent 343 put it in answer to question A1. In spite of their fears, they expressed a strong desire to learn CBT yet reported comparatively little interest in how having a CBT qualification might benefit their careers.

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[4] For quotations on employment, a job/profession tag is added.

6.1.3: *Trainees with a psychodynamic model preference at pre-training:*

Like most other trainees, trainees with an initial preference for the psychodynamic model came into CBT via either experience of having therapy:

> I did a Diploma and it had a requirement for personal therapy... The counsellor that I went to used the cognitive approach and used imagery. Within the cognitive approach ... I worked on some health issues that I had and it seemed useful **(361/F/A1/PSYDYN).**

or from experiences doing therapy:

> It began as a natural outcome to what I was already doing – working at Relate... In my (psychodynamic) training the message was very much 'This is the only way to do things' ... I thought it *was* the only way... I was a sort of true believer, I suppose... I expected CBT to fit in with psychodynamic because they both look at the client's learning history. **(355/F/A1-4/ PSYDYN)**

These trainees were generally impressed by the efficacy evidence supporting CBT yet also wanted to retain a significant psychodynamic strand in their practice:

> I think that about 80% of clients benefit from psychodynamic therapy, 20% are left cold by it. (Later)...I began to get the sense that some clients could really benefit from shorter-term work; things like panic and PTSD could be helped quite well in a format of 6 sessions.... My (psychodynamic) supervisor told me to change my language and suspend belief (during CBT training). I was worried I might lose the stuff I'd learnt. **(361/F/A4-5/PSYDYN)**
>
> I felt that psychodynamic therapy did work but the sessions could wander a bit. I was unsure how CBT might fit my practice **(480/F/A4-5/PSYDYN).**

Like many PCT trainees, these trainees recalled having reservations about CBT similar to those described by Persons et al (1996):

> I had a tendency to react very negatively to prescribed treatment and the treatment manual. It seemed too cut and dried and perhaps ignored the relational aspect of the work. It made me very resistant and I still think it is very important to find your own way of doing it **(361/F/B11/PSYDYN).**
>
> I feared that it might be cold and over-structured... I feared it (i.e., CBT) would seem cold and remote to my clients... I don't mind taking notes but it's that clipboard and pen that I couldn't get past... I might lose all my previous stuff and become regimented; they wouldn't be able to see *me*! **(480/F/A7/PSYDYN)**

The psychodynamic trainees had similar employment backgrounds to some other trainees: mixing independent practice with sessional employment (e.g., offering block 'sessions' in units of 3 hours of therapy to employers like EAPs (Employee assistance programmes) and the NHS on several days per week. Some of these employers did show some interest in developing CBT but were not in a position to offer practical support:

> I was mostly self-employed at the start of the course but was doing some work for EAP companies as well. I had no real practical support, you know with fees towards doing the course and that sort of thing. One EAP company was interested in the CBT bit. I now work in

> the NHS part-time too: they are quite interested in CBT – that may have helped me get that work **(361/F/A8/PSYDYN).**

In summary, there were three interviewees who had described their initial orientation as Psychodynamic and they showed rather different responses to the questions. One, Respondent 355, had become 'frustrated' (response to question A2) with the psychodynamic approach and was very ready for a new theoretical impetus. She did have many fears about the ideas or practice of CBT. Like respondent, 343, she felt that CBT could add more focus on how action followed understanding in therapy. She also thought that she could retain what she still valued about psychodynamic therapy, namely its emphasis on the relationship. She entered the training therefore as a potential CBT 'convert'. Respondent 361 seemed much more desirous of maintaining her psychodynamic stance and saw the chance of undertaking CBT training in a more pragmatic way. Her work had developed quite strongly towards providing sessional services for the NHS. She was aware of the growing interest in evidence based practice in the NHS and she therefore saw CBT training as 'additive'. She expected that CBT training would strengthen her market appeal in this field. Respondent 480 took a stance that was quite close to that of 361 and indeed they shared the same type of practice setting in NHS sessional work. They did express some of the reservations about CBT described by many of the PCT trainees and Persons et al (1996) but took a more pragmatic view on overcoming these difficulties and of finding a way to use CBT to their own and their clients' advantage.

6.1.4: *Trainees with an Eclectic/Integrated model preference at pre-training:*

Eclectic/Integrative trainees also described being exposed to a variety of 'schools' of therapy and being attracted to some and repelled by others:

> I was doing a psychodynamic training and (after an incident on the course) I began to look at the whole thing... It spilled out ... in terms of boundaries, supervision, experiential groups, I just didn't feel it was held... personal therapy was part of the course but they told you which therapist to go to ... (and it turned out that these therapists)... were part of the organisation! On top of that, you were never told that you had to go to extra workshops, which, funnily enough, were organised by members of the organisation too. It just seemed so self-financing, self-perpetuating. You couldn't possibly think of doing counselling practice until you had been with them for 5 years. It just made me question the whole thing **(357/F/A1/ECINTEG).**

For Integrative/Eclectic trainees, part of the attractiveness of CBT was its increasing reputation as a form of evidence-based practice. A case for Integrated/eclectic therapy is that one may 'cherry pick' what seem like the most effective ideas and methods from different models. Though eclectic/integrative work was attractive, one of its downsides may be that it could defuse expertise and limit the scope of therapy:

> **I wouldn't say that I had a strong belief in its' (i.e., eclectic/integrated therapy's) effectiveness... I was a bit worried about just dipping in and out and not doing anything as professionally as I might have... I had great hopes of CBT. It fitted me. I am a bit directive as a person so I needed to manage my CBT practice so I didn't come over as too directive (357/F/A4-5/ECINTEG).**
>
> **I thought eclectic work was good in some areas but uneven and not very good for things like anxiety and depression... I thought CBT could add a lot to it... CBT gives you angles that can take you into peoples' worlds (473/F/A5/ECINTEG).**

These trainees expressed other more pragmatic career factors as motivations for doing this particular CBT training course:

> **The possibility of getting a Masters was an important part of it. It is a thing that is a big advantage in nursing right now, to be honest (360/F/A6/ECINTEG).**

They had the same mixed response from employers as other trainees but did include at least one positive story of support:

> **My support was excellent. I got 50% fees and 50% study leave and they were often quite generous in increasing that. My senior nurse was very, very encouraging... they seemed far keener on CBT than all that touchy-feely stuff in counselling! (360/F/A8/PSYCHIATRIC NURSE)**

In summary, the trainees who preferred an Integrated/Eclectic model at pre-training showed, as other trainees did, quite pragmatic attitudes towards learning CBT. They had rather mixed experiences of trying non-CBT models – including experiencing a lack of integrity of approach in working with multiple models. They also stressed the advantages of the clinical reputation of CBT in obtaining what they considered personal professional advantage, for example in the NHS, as expressed by Respondent 360. In her case, employers seemed to back her perception by offering greater support than had been offered to other trainees.

6.1.5: Pre-training: Data summary:

In summary, trainees described embarking on CBT training as a result of either hearing about CBT during other training or from experiences in therapy practice, mainly as counsellors but sometimes as clients. They were often considering other

options such as humanistic or psychodynamic therapy and making positive and negative appraisals of the options on offer. Trainees with initial preferences for models other than CBT often expressed doubt about the effectiveness of those models, against which the efficacy evidence on CBT seemed attractive. In this study, PCT trainees were most likely to have the reservations about CBT described in the literature (Persons et al, 1996; McLeod, 2001), including images of CBT as being over-structured and cold. The status of CBT in the efficacy literature, however, inspired the idea that learning it could lead trainees towards being more effective and professional in their work. For some, more strongly represented in the Psychodynamic and Integrative/Eclectic trainees, CBT training was linked to more pragmatic motivations such as career advancement, whereas for the person-centred trainees, it seemed more linked to the satisfaction of being more effective practitioners. For trainees who began training with a CBT preference, motivations for training contained elements of both pragmatic career considerations and a desire to improve practice.

Some of the trainees considered that their current models contained areas of ineffective practice. Trainees' hopes centred on making positive changes to their practice, often accompanied by a strong desire to be seen as more professional. Fears were dominated by failing as students and/or practitioners. For PCT trainees, there was often an additional fear of not making the transition in style from PCT, characterised as 'non-directive', to CBT, characterised as 'directive', an aspect of CBT practice that seemed threatening to their previously held values.

The degree of employer support for CBT training was generally weak, although some trainees were mostly self-employed and were not therefore in a position even to claim such support. Some trainees got psychological support from immediate colleagues but few got much significant practical support with fees, other expenses or even leave time to attend training. The employer of only one trainee, an NHS psychiatric nurse, of the 24 interviewed offered anything like a commitment to encouraging CBT training, backed by financial support of the trainee.

THEMATIC CHART 1: CBT TRAINEES AT PRE-TRAINING:					
1.1/2: How/when initial engagement with CBT?	**1.3: How effective was first model?**	**1.4: Practice model fit with CBT?**	**1.5: Factors influencing final decision?**	**1.6: Hope and fears**	**1.7: Employers' support of training**
1.1.1: Previous training: **342:** Previous tutors were focused on CBT **471:** I was impressed by CBT teaching on previous course. **476:** When we covered CBT in the Diploma, I realised it was the approach for me. **1.1.2: Experience as a client or counsellor:** **358:** I had therapy after suffering traumatic stress in Police service **597:** I worked as a social worker in a behavioural unit	**1.3.1: Very effective:** **342:** 100% **358:** Very strongly. **471:** Very strongly. **597:** Very strongly **1.3.2: Mixed view of effectiveness:** **476:** Confident about areas like anxiety & depression, less so about other areas.	**1.4.1: Good fit:** **342:** I thought that my CBT model would be refined and made more professional. **358:** I thought I'd be extending my practice, refining, becoming better. **471:** I thought it fitted my ideas about therapy well. **476:** I really wanted to do it but there was some anxiety about whether I could do the scientific bit. **597:** Very well. **No other categories for this group**	**1.5.1: Career development:** **342:** Previous tutor had dared me to think that I could really be a professional. **358:** The reputation of the course and of CBT would help me become a professional therapist rather than a counsellor. **476:** I wanted to know more about CBT and be more professional **1.5.2: Practical factors:** **471:** I was about to do a course in the Midlands and then realised there was one more local. **597:** Practical, pragmatic reasons, locality was a factor.	**1.6.1: Hopes:** **342:** To complete the course and be more competent and professional **358:** I hoped that I had found the right academic and career direction. **471:** I wanted to pass and become a proficient practitioner – good at what I do. **476:** To make myself more marketable, to have more work opportunities. **597:** I wanted to refresh and relearn CBT. **1.6.2: Fears:** **342:** Fail the course. **358:** I wouldn't be good enough academically. **471:** Personal issues. **476:** Failing the course, also financial worries. **597:** That my age might make study difficult.	**1.7.1: Not relevant** **342:** Self employed **358:** I had just come out of my previous (police) work and was still exploring other employment at the start of the course. **471:** I had withdrawn from clinical psych training and was developing another employment track. **476:** I was employed as a teacher when I started the training so it wasn't relevant to my employers. **597:** My employment was in the NHS but not in therapy service so my employers were interested but not in supporting my training ***No other categories for this group***

THEMATIC CHART 2a: PCT TRAINEES AT PRE-TRAINING:					
1.1: How initial engagement with CBT?	**1.3.1: How effective did you see first model?**	**1.4: First model's fit with CBT?**	**1.5: Influences on final decision to do CBT training?**	**1.6: Hopes and fears of training**	**1.7: Employers supportive of CBT training?**
1.1.1:Previous training: **345:** I had mixed feeling from previous training but a tutor talked me through my fears about the directive nature of CBT. **347:** Saw tutor doing CBT and liked the style. **349:** Previous training, CBT was less wishy-washy. **351:** Interest came from Diploma course. I liked the problem solving bit **1.1.2: Experience as counsellor or client:** **343:** I inspected training courses and visited a CBT course and was impressed by the teaching. **346:** I had some personal therapy using CBT and it made sense.	**1.3.1: Very effective:** **346:** About 100% though I couldn't have given a rationale why. **1.3.2: Mixed view of effectiveness:** **343:** I adhered to its values but could see some areas where the practice wasn't strong enough. **345:** I believed in PCT quite strongly but wondered if it was 'enough'. **347:** It was PCT values that really appealed to me but I had some doubts about its effectiveness. **349:** Was PCT but I was getting more eclectic as sessions seemed to get stuck. **351:** I thought that PCT was effective until I went into the Probation service. I started thinking about measuring change.	**1.4.1: Good fit:** **346:** I thought it could be a more focused version of what I was doing. **1.4.2: Mixed/ uncertain:** **343:** I did feel a bit mixed about CBT but I was less concerned with that and more with how it could offer direction to clients. **345:** I began to think it would fit when I understood that CBT did have some interest in early experience. **347:** I was unsure about that but as I got closer to the training, I felt more optimistic. **349:** Afraid it might be over-structured, esp. the idea of agenda. **351:** I thought that PCT could combine with a problem solving approach but CBT fitted even better.	**1.5.1: Career:** **No responses in this subgroup** **1.5.2: Specifically to learn CBT:** **343:** I was secure professionally but I'd seen a gap in my practice and thought CBT could fill it. **345:** Mainly learning CBT. I had only vague ideas about changing jobs at the start. By the end of it, I knew I wanted to change. **347:** It was nothing to do with career then, I just wanted to learn a pure CBT approach. **349:** I didn't really think that I'd get the MA so it was purely about learning CBT. **351:** To learn CBT: it fitted my personality. **1.5.3: Academic:** **346:** The reputation of the University: getting an academic qualification was a dream to me.	**1.6.1: Hopes:** **343:** Learning relevant skills. **345:** Excited about achieving Masters and completing programme. **346:** Finish the course and get the qualification **347:** Wanted to do structured & effective work. **349:** Have a good understanding of CBT, be a better counsellor. Some vague hopes of career advantages. **351:** I wanted to learn model thoroughly: not a workshop **1.6.2: Fears:** **343:** I'd spent years learning to be non-directive; I feared CBT could push me back to it. **345:** Failing: a schema there! **346:** It was the academic side that was the big fear for me. **347:** The fears were all academic: that I wouldn't get in and that I'd fail it if I did! **349:** That I wouldn't understand it and that I might lose the skills I had already. **351:** That I wouldn't learn it.	**1.7.1: Not relevant:** **346:** Not employed at start of the course. **1.7.2: Positive:** **343:** My employers did back me but for CPD not specifically related to CBT. 351: My agency (drugs) got a contract to do Probation work. I got a day's paid leave to come to do the course **1.7.3: Indifferent:** No responses in this subgroup **1.7.4: Mixed:** **345:** They thought they'd done enough by that stage. They gave me time off but no help with fees. **347:** Part time: my employers weren't interested in supporting any kind of training. **349:** Worked in NHS: no support at time but some retrospectively

THEMATIC CHART 2b: PCT TRAINEES AT PRE-TRAINING					
1.1: How initial engagement with CBT?	**1.3.1: How effective did you see first model?**	**1.4: First model's fit with CBT?**	**1.5: Influences on CBT training?**	**1.6: Hopes and fears of training**	**1.7: Employers support CBT training?**
1.1.1:Previous training: **469:** CBT in Dip. Really knocked me for six. **477:** It seemed useful when I did the Diploma. **595:** On previous training, things like this appealed to my Thinking type (MBTI) **1.1.2: Experience as counsellor or client:** **353:** Talking to colleagues about CBT training they had done and thinking that could work for me. **468:** Previous training was PCT; it was my work supervisor at the hospital that encouraged me to think of CBT. **472:** Worked as student counsellor and came to think that I wasn't effecting enough change as PCT counsellor. **1.1.3: Other:** **356:** I just kept hearing about CBT on the media. I felt stale and it seemed worth a try.	**1.3.1: Very effective:** **353:** It seemed where we were heading. I thought it was effective for most clients. **477:** Very strongly: though somewhat dependent on type of client **1.3.2: Mixed view of effectiveness:** **356:** As time went on, I was only partly convinced about its effectiveness. **468:** I felt I was more directive than others in my group. It wasn't enough, Carl Rogers. **469:** Strong belief in person-centred values at first but then doubts came, esp. for sort term work. **472:** Between strong and weak, more on the weak side. I really became dissatisfied with what I could offer. **595:** I quite strongly considered it to be effective, though I also had reservations.	**1.4.1: Good fit:** **353:** Because solution-focus was in our model, I thought that CBT would fit there yeah. **468:** I thought I could integrate it: that it would fit quite well. **472:** I thought that the students would like it and it would fit. **477:** I felt it fitted with me so it should fit with my model. **1.4.2: Mixed/ uncertain:** **356:** I thought CBT might add what I thought was a bit missing in PCT. **469:** I stayed with person-centred despite my doubts but hoped that other things could enhance it. **595:** I did wonder if CBT was a bit cold and impersonal but I hoped that they could be integrated.	**1.5.1: Career:** **468:** I was pushed by the Supervisor who said it would help me in the hospital. **469:** I did well on the Diploma and my tutor encouraged me to go further and I also saw that agencies were looking for effective short term work. **477:** Part of me wanted to finish the Newport programme but also enhance my career by getting accreditation. **595:** I was looking for career change but saw CBT training more options. **1.5.2: Specifically to learn CBT:** **353:** I did a 2-day course - Yes this clicks with me. **356:** I wanted to do CBT to increase my effectiveness. It seemed to be in vogue too. **1.5.3: Academic:** **No responses**	**1.6.1: Hopes:** **353:** Impressed Socratic questioning: could make work more purposeful. **356:** That I would be more effective. **468:** Enjoy as it was closer to my real preferences. **469:** Enhance my practice. **472:** It would be really useful for my practice. **477:** I wanted to do CBT in a thorough way. **595:** I hoped it would get my work more on track. **1.6.2: Fears:** **353:** I wouldn't do it well enough to make difference. **356:** That I wouldn't cope with the academic side. **468:** Fear of failing course. **472:** Losing skills, becoming a CBT automaton. **477:** Anxious about being structured: drift from PCT. **595:** Feared that CBT would be incompatible with my values.	**1.7.1: Not relevant:** **No responses** **1.7.2: Positive:** **468:** I was actually a secretary at the hospital but also did some therapy work, it was the therapy side that encouraged me and supported me. **1.7.3: Indifferent:** **356:** I didn't think they would help but I sort of kept to myself: I didn't want to feel beholden to anyone. **595:** Let me get on with it but no interest/money support. **1.7.4: Mixed:** **353:** Interested in the CPD form then ziltch thereafter. **472:** They paid my fees – after a fight! – gave me leave but didn't have a clue about CBT. **477:** Some in my agency were very anti-CBT. The agency was very PCT. They did offer support but no money.

THEMATIC CHART 3: PSYCHODYNAMIC TRAINEES AT PRE-TRAINING					
1.1/2: How/when initial engagement with CBT?	**1.3.1: How effective did you see first model?**	**1.4: First model's fit with CBT?**	**1.5: Influences on final decision to do CBT training?**	**1.6: Hopes and fears of training**	**1.7: Employers supportive of CBT training?**
1.1.1: From previous training: **480:** I heard about it on my previous course and liked the sound of it. **1.1.2: Experience as counsellor or client:** **355:** I was moving naturally towards a more action-orientated approach. **361:** I had some cognitive therapy as course requirement	**1.3.1: Very effective:** **361:** I thought that about 80% of clients benefited from psychodynamic work. **1.3.2: Mixed view of effectiveness:** **355:** Originally I thought it was the only way. I was a true believer… but doubts set in the more I practiced. **480:** I felt it worked but the sessions could wander a bit.	**1.4.1: Good fit:** **355:** Expected fit because CBT also seeks to understand the client's past – but in terms of learning history. **1.4.2: Mixed/ uncertain:** **361:** Unsure. My supervisor told me to work on language and suspend disbelief. I was worried I might throw away stuff I'd learnt. **480:** Unsure: feared CBT might be 'cold' and 'over-structured'.	**1.5.1: Career development:** **480:** It was a career thing mainly. CBT was 'up and coming'. I wanted a specialism and to be taken more seriously. **1.5.2: Specifically to learn CBT:** **355:** I was attracted to CBT. I'm Christian and prayed about it. It also fitted in with moving to this area. **361:** I didn't just want a 'toolbox'. I wanted to do a substantial course and really understand the underlying concepts.	**1.6.1: Hopes:** **355:** That I would enhance my practice. **361:** To add something useful to my practice. **480:** That CBT wouldn't be as cold as I feared it would. **1.6.2: Fears:** **355:** That I wouldn't understand the course and fail the academic part: feared that there might be an age effect. **361:** Not meeting academic standard. Getting de-skilled. **480:** Feared CBT was cold: reacted negatively to 'agenda' (reminded of clipboard & pen). Losing skills, esp. to make a therapy relationship.	**1.7.1: Not relevant:** No responses **1.7.2: Positive:** **355:** My employers were positive but I was moving. Here the training has helped me get work in NHS. **361:** NHS employers were enthusiastic. I got 50% funding & leave. **1.7.3: Indifferent:** **480:** I was doing some work for NHS but they wouldn't have been interested, would have feared me asking them to pay for my training.

THEMATIC CHART 4: INTEGRATIVE/ECLECTIC TRAINEES AT PRE-TRAINING:					
1.1: How initial engagement with CBT?	**1.3.1: How effective did you see first model?**	**1.4: First model's fit with CBT?**	**1.5: Influences on final decision to do CBT training?**	**1.6: Hopes and fears of training**	**1.7: Employers supportive of CBT training?**
1.1.1: From previous training: **357:** I entered a psychodynamic training and I got very unhappy about the agency running it, esp. their line on having therapy as part of training… so I was looking for something else. **473:** Although Relate is very psychodynamic, the training on psychosexual counselling is quite behavioural and that took me to CBT. **1.1.2: Experience as counsellor or client:** 360: I work in the NHS psychiatric sector and we were getting more and more about evidence based practice and CBT was figuring in that.	**1.3.1: Very effective:** **1.3.2: Mixed view of effectiveness:** **357:** I felt a bit confused about how all the ideas of an eclectic/integrated approach were supposed to work: I didn't have a strong belief in the effectiveness of that. **360:** Maybe a 5 out of 10. I thought it was a fair grounding but I wanted something more concrete and specialised and that was CBT. **473:** I thought eclectic work was good in some things but was uneven and not very good for anxiety and depression.	**1.4.1: Good fit:** **3** **57:** I thought that CBT was going to fit but it was not so much with an eclectic model, more with how I was and how I felt. **360:** I was optimistic about that. There were others in the Trust doing CBT so I felt it could work for me too. **473:** I thought it would fit into psychosexual work. CBT gives you 'angles' that can take you into peoples' worlds. **1.4.2: Mixed/ uncertain:** **No responses from this group**	**1.5.1: Career development:** **360:** The possibility of getting a Masters was an important part of it. It is a thing in nursing now. **473:** To be honest, I felt at a loose end: between jobs and felt that some more training could give me and my career a boost. **1.5.2: Specifically to learn CBT:** **357:** I know this will sound a bit vague but it did just feel right. I had left a different area of work and wanted to be sure that I trained in would count.	1.6.1: Hopes: **357:** I wanted to learn a more focused model of practice. **360:** I wanted to pass and get the Masters qualification. **473:** I wanted to join a learning community and get a respectable qualification. **1.6.2: Fears:** **357:** I was quite scared I'd fail. I felt that I had less training and experience than the others. **360:** I was scared I wouldn't get my head round it. Academic work is not strong point. **473:** I was a but scared of the academic side, esp. as I joined the course a little bit later than the others.	**1.7.1: Not relevant:** **No responses from this group** **1.7.2: Positive:** **360:** My senior nurse was very enthusiastic and I got 50% support on fees and study leave. They were dubious about 'counselling' but felt better about CBT! **1.7.3: Indifferent:** **No responses from this group** **1.7.4: Mixed:** **357:** I was working for a voluntary agency. They did make some promises of support but didn't follow up on them. I thought the woman who supervised me felt a bit threatened by me doing the training. **473:** They were encouraging but never gave any practical support.

6.2: The training period:

The questions on the training period asked about the morale and anxieties of trainees at different times of the training process, including classroom, practice and employment experience. They also ascertained how trainee's perceptions of the strengths and weaknesses of CBT developed.

6.2.1: *Experience of training: trainees with a CBT preference:*

Trainees who began training with a preference for CBT gave mostly affirmative accounts of their experience at mid-training:

> I was feeling pretty good because I felt that I was putting the trimmings on it. My tape assessment was, I think, above average so I was pleased with that. The theory was no problem. So I was feeling generally favourable about the training. **(342/F/B9/CBT)**

> I was chuffed because I did well in the assessment... and I was finding that CBT worked well with clients. **(476/F/B9/CBT)**

Only one of these 5 trainees failed to report this kind of experience. The preoccupation with assessment at mid-training was evident in this particular account:

> I feared assessment... and then there was a hiccup with my assessment when two tutors took different views on one aspect of my tape... I was relieved when it was resolved by the more experienced tutor who had come down on my side. **(471/F/B9/CBT)**

When asked what they thought had been the most valuable gains from training, as with the whole trainee group, these trainees' answers divided roughly equally between references connected to CBT theory and to CBT practice. The references to CBT theory were dominated by references to the conceptualisation (formulation) model in CBT. This was widely seen as being relatively clear and easy to apply. It was also seen as giving a clear theoretical spine to CBT work:

> I gained a lot from the CB conceptualisation process. I saw that it was fuller and richer than I had realised: not just 'here and now' but deeper elements from the client's history as well... the most psychodynamic aspect of CBT, I reckon **(476/F/B10/CBT).**

Conceptualisation also featured prominently in points that proved most difficult in the training:

> I sometimes wondered what exactly was meant by 'conceptualisation'. Trainees seemed to have different versions of it, and so did tutors at times! **(476/F/B10/CBT)**

Another main area of both gain and difficulty was CBT practice. Various aspects of the practice model were highlighted, including applications of CBT and using CBT structure:

> CB applications to problems like depression were most helpful. I thought to myself, 'You are in Big School now' **(342/F/B10/CBT).**
>
> The structure of CBT was interesting. I tried to use it all the time, as best I could. My previous style had been quite unstructured so that was a challenge but a rewarding one **(597/M/B9/CBT).**

Other trainees mentioned appreciating CBT skill learning:

> I liked skills learning via video and audio and getting honest feedback on how I had done **(358/M/B10/CBT).**

A variety of other issues concerning the actual training course itself were mentioned as difficulties:

> The sheer amount of material to be learnt was challenging, not to mention certain complex bits on research methods **(342/F/B11/CBT).**

Other difficulties concerned implementing practice. Implementation problems included remembering what one was supposed to do with clients and why one was supposed to do it. The theme of over-deliberation in implementation was often referred to:

> I wasn't always sure how and why I was supposed to target certain areas... you know, how were these interventions supposed to lead to change for the client? **(358/M/B11/CBT)**
>
> I found it difficult to move from very consciously applying the skills to a more natural form of CBT practice **(597/M/B11/CBT).**

The crux of actually learning of CBT came when trainees tried to apply it with clients in their everyday practice setting. Some anxiety was attached to the assessment of this practice because trainees were continually looking for a taped session good and comprehensive enough to submit for assessment. There was also a more general everyday struggle to make CBT work in practice. One question in the interview asked how well trainees found that CBT worked with their clients during training. Two themes that arose in responses were degree of success (how well CBT could work) and range of suitable clients (with whom CBT would work). The trainees who had begun with a CBT-orientation tended to report more uniformly successful practice and success with a wider range of suitable clients than other trainees:

> I didn't really come across many clients who couldn't run with it (CBT), though I had to vary the pace and form of it with some clients **(358/M/B12/CBT).**

> It worked well with most clients. When it worked, it worked really, really well… but not with all clients obviously **(471/F/B12/CBT).**
>
> CBT worked pretty well most of the time… some clients didn't respond to it but that was my inexperience probably **(597/M/B12/CBT).**

Reports of successfully applying the model are reflected by the greater degree of feeling a sense of having a good grasp of theory and practice at the end of training by trainees with initial preference for CBT:

> I felt that I learned a lot. I had certainly read a lot… as good a grasp of CBT as one year's learning allowed **(597/M/B13/CBT).**

In summary, the trainees who had preferred the CBT model at pre-training largely reported that they emerged from CBT training having experienced a successful learning experience. They felt confidence in their acquisition of skills and that they had widened the number of areas in which they were able to use CBT. They had appreciated many areas of the training but were also critical of some: Respondent 471 thought skill teaching could have been 'stronger' and Respondent 476 found some of the teaching on formulation contradictory. Their employment situations were changing and they felt that having the training and/or qualification had aided their quests for employment. Respondents 358 and 597 had obtained CBT-related posts between finishing the course and coming for interview. Respondent 476 reported starting to job hunt and told of the interesting experience where her qualification may have been a disadvantage in that the manager of the agency was less well qualified. The reports on employment seeking were perhaps signs that whilst CBT has made inroads in many agencies during the period of the research, knowledge of and preference for CBT was still limited to certain agencies and areas.

6.2.2: Experience of training: trainees with a PCT preference:

Compared to the trainees preferring CBT, the person-centred trainees were more likely to report some specific unfavourable experiences. These included the anxieties connected with assessment and, as reported in Chapter 5, they were more likely to fail CB skills assessment items at all stages:

> Around that point (half way through) I felt pretty depressed and worried… I had not been referred or failed on any piece of work for 15 years **(595/M/B9 (/PCT).**

They also reported difficulty implementing CBT practice in their everyday client work. Implementing the CBT structure was a challenge that could be both rewarding and perplexing.

> For me, it (i.e., the main difficulty) was the structuring of the sessions… One student said CBT is tidy and tidy is a good word for it; sessions with a start, middle and end gave me an experience that things could be done. **(346/F/B9/PCT)**

> I had problems remembering the structure we were supposed to follow… especially trying to fit conceptualisation into it. **(472/F/B11/PCT)**

One frequently reported reaction was to try too hard and to over-structure the therapy work, a tendency that has been reported in other training studies (McKay et al, 2001; Henry et al, 1993):

> The assessment was dreadful… for a while, I seemed to lose trust in myself and I became over-structured for a time… I had to do it 1, 2, 3, 4, 5… I couldn't play with it… The overall approach of CBT was neat and coherent. The clarity of Beck's thought and the way he used the underlying principles was striking to me **(343/F/B9-10/PCT).**

> This for me was the 'confusion period'… I realised that I had been working quite willy-nilly with clients… Perhaps it was not so much 'confused' and then I was probably trying too hard to be structured… **(351/F/B9/PCT)**

Realising that one had become trapped by one's own stereotypical picture of CBT sometimes sparked a way of detaching oneself from 'trying too hard':

> I was a victim of my own stereotype of CBT at time… I saw CBT as very rigid and this got in the way of me learning it for a while. I was trying too hard to be CBT **(349/F/B11/PCT).**

Some PCT trainees now had to make a decision on how to handle this issue:

> I realised… that I was not going to just swan through this one… I had to cut a deal with my aversion to the manualised approach and learn how to do the good stuff **(595/M/B9/PCT).**

As with other trainees, learning CBT formulation (conceptualisation) both challenged and rewarded PCT trainees:

> I couldn't get conceptualisation at first and it drove me bananas for a while. I think it was the jargon terms that put me off **(347/F/B11/PCT).**

> Before the course, I'd thought that CBT was just about fixing things, so seeing how conceptualisation could drive the therapy was enlightening **(477/F/B9/PCT).**

Conceptualisation sometimes referred to an idiosyncratic formulation of an individual client but the same concept was capable of use in understanding wider areas of psychological problems, such as anxiety disorders and depression:

> I really liked going into the separate areas such as depression and OCD – the applications of CBT. My former nursing self could connect with that… I really feel it would have great to focus even more on that **(472/F/B10/PCT).**

Skill learning and self-development groups have not always been included in CBT training (Bennett-Levy, 2001). They have, however, been strongly associated with the more experiential nature of PCT training (Mearns, 1999) and this may account for some of the 'confusion' surrounding it for PCT trainees:

> Previous courses I had done had self-awareness work and I wasn't sure if that was supposed to be part of CBT... That question seemed to divide the trainees **(346/F/B11/PCT).**

Other points focused on positive views about more general aspects of learning of CBT theory and practice, including skills. Trainees sometimes mentioned specific skills:

> I liked the tools that CBT made available to me... I liked being able to identify cognitive distortions and use Socratic Dialogue **(595/M/B10/PCT).**

They also liked the style in the way skills were used. The idea of 'collaboration' was especially important in reassuring PCT trainees that they were not practising in an overly directive manner:

> The fact that I was helping my clients with CBT was really helpful to me, especially when it could be done collaboratively, for example, writing conceptualisations with the client **(351/F/B10/PCT).**

Perhaps because the individuality of clients is emphasised in the Rogerian model, PCT trainees were also reassured by the fact that CBT had idiographic conceptualisation:

> I especially liked the way it takes you to what the client is thinking and feeling... about their situation... it was almost like putting a tap on, you know... And you think 'I have got your internal dialogue here' and have access to some ideas that might help with that **(353/F/B10/PCT).**

They were, however, more wary of conceptualisation linked to a structured therapy protocol:

> At first I was very resistant to the idea of following a CBT protocol... later I moved to seeing them as a source of things that I could try **(595/M/B11/PCT).**

Other reported difficulties were more idiosyncratic:

> I felt anxiety about all there was to learn... for example, if you were dealing with a client with anxiety, then you had to know about the CBT approach to anxiety... In person-centred, the approach was always the same, no matter what the problem was. **(356/F/B11/PCT)**

Trainees who began with a PCT preference reported more difficulties in implementing CBT, compared to those who began with a CBT preference. Whilst some reported distinct success:

> It fitted like a glove really... It worked very well with most of my clients **(347/F/B12/PCT).**

Others reported mixed success, sometimes in directions different from those they'd expected:

> I guess mixed results really: funnily enough, [*Agency* - previously reported as having many workers who were anti-CBT] clients would fit into it more because they had lots of anxiety and depression. **(477/F/B12/PCT)**

Perhaps because of these mixed results, PCT trainees described slower resolution of training difficulties as they moved to the end of the training process:

> There were still some difficulties that I hadn't completely resolved – for example, conceptualisation skills. I have solved these since but then there was still some anxiety about them. **(477/F/B13/PCT)**

Others, however, saw themselves as having come through their sense of dissonance:

> I was over my little crisis by then. I had found my own way of doing CBT instead of having to 'follow' it. My work started to have a good solid feel to it **(343/F/B13/PCT).**

Such growing confidence was easier to sustain when concrete results affirmed progress:

> I was definitely working in a different, more streamlined way… I was losing fewer clients and got more measurable change **(346/F/B13/PCT).**

Though for some confidence remained high even when reverses occurred:

> I was so angry with myself for not passing the final tape first time… just silly things that I had forgotten to cover… but I knew it was just a bad tape, it didn't stop me thinking that I could do it **(468/F/B13/PCT).**

PCT trainees were more likely to report on-going anxiety even after passing their assessments:

> I felt quite reasonably confident at the end but I knew that I still had things to work on. I have this funny thing about confidence in myself: even though I had passed the final tape and I could see others hadn't **(356/F/B13/PCT).**

In summary, the PCT trainees mostly negotiated the CBT training programme successfully. As other trainees did, they reported fluctuations and anxieties during the process (Bennett-Levy & Beedie, 2007), especially those connected with implementing CBT in a way that was congruent with their values. Some saw benefit in adopting more structure for therapy and were able to loosen their value constructs enough to allow them to do this relatively easily. For others, there was more of a sense of crisis, often coinciding with the actual periods of skill assessment. Various strategies were employed to surmount these crises, including moving away from 'trying too hard to be CBT' (351) to allowing oneself leeway to 'play with' implementing CBT. These problems, however, probably did delay the acquisition of competence for some of the trainees. In some cases trainees retained a distinct awareness of distinct weak spots even when they had passed assessments (343, 477).

6.2.3: Experience of training: trainees with a Psychodynamic preference:

Trainees who began training with a psychodynamic preference shared many of the experiences of other trainees at mid-training, including the anxiety of learning and being assessed.

> Apart from being terrified of the assessment, I did think that I had got the actual basic idea of it and that I could use it... I was starting to feel quite excited. **(480/F/B9/PSYDYN)**

Unlike the PCT trainees, however, they now reported fewer reservations and were beginning to find favourable aspects of CBT, once training was underway:

> The (CBT) structure was very helpful. It was good to be clear with the client and write things down. I found it helpful to think about what homework might be helpful and added that on **(361/F/B10/PSYDYN).**

> I found the CBT conceptualisation model easy to understand and use: for example, for panic, I still use that... The structure was very helpful. It was good to be clear and write things down. I found it helpful to think about what homework might be helpful. **(361/F/B9/PSYDYN)**

They reported gains and difficulties in both the theory and practice of CBT similarly to other students:

> There is a lot of material to learn and because of my enthusiasm I always want to learn it all... which of course is impossible **(355/F/B11/PSYDYN).**

> I had a tendency to react very negatively to the idea of 'prescribed treatment'. It made me very resistant and, I still think it is important to find my own way of doing it **(361/F/B11/PSYDYN).**

They did, however, report more mixed experiences of implementing CBT with clients than some others:

> It worked sometimes and sometimes it didn't... I had a tendency to want to try it on everyone I met **(355/F/B12/PSYDYN).**

> Well, I knew it wasn't seamless but it was 'good enough'... My style had certainly become more distinctive... I was able to be more upfront with clients and explain the rationale of what I was trying to do. It seemed to work pretty well... I was always keen to assess for suitability and that is something that I have stuck with as good practice **(361/F/B12-13/PSYDYN).**

The three interviewees from a Psychodynamic background did well in overall assessment at mid and end of training – failing to demonstrate competence on only one item between the three of them. This item was retrieved at the first opportunity. They generally reported successful learning experience, which has resulted in one, 355, 'converting' to CBT, whilst the other two, 361 and 480, report using CBT more pragmatically and retaining psychodynamic elements to their practice. 480, however, was one of the only 3 trainees who had gained CB therapist accreditation by the time

of the interviews, though more have done so subsequently. These trainees also reported some difficulties in implementing CBT that are similar to those reported by PCT trainees but they did not describe them in terms of protracted crisis, as some of the PCT trainees had.

6.2.4: ***Experience of training: trainees with an Integrative/Eclectic preference:***

Trainees with this preference appraised progress at mid-training in a similar way to CBT and Psychodynamic-oriented trainees but were more favourable than PCT trainees:

> I failed assessment items and was naturally a bit gutted... but... I thought I would get there in the end with the practice skills. It was the academic work that had me more worried. It is something that I have always struggled with **(360/F/B9/ECINTEG).**

They were attracted by both the theory and practice of CBT:

> I liked the structure of CBT and being able to write notes and draw diagrams and work in a very focused way **(473/F/B10/ECINTEG).**

When reporting difficulties about learning CBT, they quite often referred to their specific training course rather than to CBT training in general. Interestingly, this was the only point in the interview where respondents did this. Several referred to skill development groups, where trainees were encouraged to learn skills via experiential work: essentially trying CBT skills on each other's difficulties.

> I found the small group work on skills difficult because I felt exposed at time. I'd have liked to chosen whom I worked with. **(473/F/B11/ECINTEG)**

Attempts to implement CBT practice with clients were generally successful but, as with other trainees, the question of client suitability arose:

> I worked in a hospice and not all clients were suitable... but some did work well with it... my supervisor was a bit anti and that didn't help. Retrospectively, I think she was a bit threatened by my training **(357/F/B12/ECINTEG).**

These trainees reported having a reasonable grasp of the model by the end of training but reported still needing to work on some aspects:

> I reckon that my practice knowledge was good but I wasn't so sure about theoretic knowledge but then I have a personal issue there ... doubting my own thinking power and all that **(473/F/A13/ECINTEG).**

Employer responses to trainees at the end of training evoked disappointment in this group of trainees, as in others, but there was at least one more positive story:

> My employers have become quite interested... (And eventually) paid some of my fees. There is a psychiatrist who is researching treatments for PTSD, including CBT. They gave me some sessional work with him... It is really interesting work... and I will probably look to go even more specialist in time **(360/F/B14/Psychiatric nurse).**

The Integrative/Eclectic trainees reported a positive learning experience and although they reported difficulties in learning that did result in delayed acquisition of competence, they had been able to overcome these difficulties. It is noticeable that they particularly reported difficulties with the academic and knowledge based challenges posed by the training. They expressed more confidence about skills but also noted the importance of assessing client suitability for CBT.

6.2.5: Training stage summary:

There were striking similarities in the way trainees from all modalities reported their overall experience of training. Most trainees tended to report having similar types of gains and difficulties with the theory and the practice of CBT. Quite often items such as formulation and using therapy structure were specified as both a gain and a difficulty in training, indicating a challenging but eventually rewarding learning experience. PCT trainees, however, did report more difficulties and anxieties about learning CBT than did trainees from other modalities. They also reported less feeling of success and confidence than other trainees. Although most trainees starting with a non-CBT preference did have reservations about CBT, the PCT trainees did seem to have reservations that related to a sense of threat to strong personal values, relating often to the issue of 'who is in charge in therapy?' (595/M).

Most PCT trainees, however, report that a process of working through these difficulties was emerging as they approached the end of the training period so that the majority were able to be successful in the final course assessments. A relatively small minority, however, continued to have problems and therefore faced having to make further skills submissions and thus were delayed in the acquisition of competence. CBT-oriented trainees reported these difficulties much less often than PCT trainees. The results for the other two modalities, Psychodynamic and Integrative/eclectic, were mixed and may be seen as falling between the CBT and PCT groups, though these sub groups also involved a lesser number of trainees.

THEMATIC CHART 5: Trainees with CBT preference on training experiences					
2.1: How did you feel at the half way point in training?	**2.2: What did you gain most from CBT training?**	**2.3: What was most difficult in CBT training?**	**2.4: How did CBT work with clients whilst training?**	**2.5: How would you sum up your development at end of CBT training?**	**2.6: Employers' attitudes at end of CBT training**
2.1.1: Generally favourable **342:** My assessment had been above average so I felt quite confident. I felt that I was 'putting the trimmings on it.' **358:** I was quietly confident. I knew I could do it: the problem was knowing *how* it worked. My client work was going well (Gives examples). I was getting good feedback from tutors… I had a plan but still needed to respond to individual clients. **476:** I was chuffed because I did well in the assessment… and I was finding that CBT worked well with clients. **597:** I felt that course was going well. I had 'got it' and I was enjoying the course. **2.1.2: Mixed feelings** **471:** I feared assessment. There was a hiccup when 2 tutors disagreed about my tape… I was relieved that the more experienced tutor took my side.	**2.2.1: CB practice model** **342:** CB applications to problems like depression were most helpful: 'It was like being in Big School…' **358:** Things like skills learning via video and audio and getting honest feedback of how I'd done. **597:** I gained a lot really… The structure of CBT sessions was interesting… my previous style had been quite unstructured so that was a challenge but a rewarding one. **. 2.2.2: CB theory model** **471:** It was helpful to have a thorough understanding of the CB conceptualisation process **476:** I gained a lot from a fuller, richer conceptualisation model for CBT: not just 'here and now' but deeper elements of the client's history too.	**2.3.1: CB practice model** **358:** I sometimes found it difficult to know what I was trying to do, try to target with the skills. **471:** I struggled a bit initially to get a concept of what the required standard for practice skills assessment was. **597:** I found it difficult to move from very consciously applying skills to a more natural form of CB practice. **2.3.2: CB concept learning** **342:** The amount of academic learning was high: difficulty interpreting research findings. **476:** I sometimes wondered what was exactly meant by conceptualisation. Trainees had different versions of it and sometimes the tutors too!	**2.4.1: Successful** **342:** Yes, it was successful, especially with College clients, successful in a different way with mental health clients. **358:** I didn't really find any clients who couldn't run with it though I had to vary the pace and form of it with different clients. **471:** It worked with most clients… when it worked, it worked really, really well … but not with all obviously. **476:** It worked very well with most clients. **2.4.2: Quite successful/ mixed:** **597:** It worked pretty well most of the time… some didn't respond to it but that was my inexperience probably.	**2.5.1: Good grasp of theory and practice** **342:** I felt that I had a good grasp and that I had filled a lot of the gaps in my knowledge of CBT. **358:** Quite confident … even though I had failed some assessments. **471:** I felt that I had a good knowledge at that point so that I felt that I could move on. **476:** I had solved my problem with understanding conceptualisation… I asked if I could keep presenting until I got it… and I did… so now it felt like a smooth transition. **597:** I thought I'd learnt a lot …a lot of reading as good a grasp as a year allows	**2.6.1: Positive response from employers** **597:** My old job was relevant to CBT really so I left quickly and got a primary health care counselling job… the interviewers did seem very keen on CBT… anyone with CBT would probably have got the job over a PCT counsellor **2.6.2: Mixed: No cases** **2.6.3: Other:** **342:** Self–employed: question not relevant. **358:** Self employed but did job as staff counsellor a little later. **471:** I'm choosing to stay self-employed at present… not sure if it may help later. **476:** Having been trying to get a job in a new area… no luck so far… even felt qualification might have a hindrance… I had more than the interviewer.

THEMATIC CHART 6a: Trainees with PCT preference on training experiences:

2.1: How did you feel at the half way point in training?	2.2: What did you gain most from CBT training?	2.3: What was most difficult in CBT training?	2.4: How did CBT work with clients whilst training?	2.5: How would you sum up your development at end of CBT training?	2.6: Employers' attitudes at end of CBT training
2.1.1: Generally favourable **345:** I was practicing it and becoming more structured all the time. I didn't meander off it… I didn't do anything else other than what was necessary. 2.1.2: Mixed feelings: **343:** Assessment was awful: I was too structured & lost trust in my self **346:** De-motivated: I realised how unstructured my work was. Assessed results were less than expected. **347:** I was quite anxious at that point… not so much about the assessment as such but more about getting the right sort of client **349:** I'd been through lots of doubts and internal struggles - it was just starting even out at that point. **351:** I was trying too hard – frustrating!	2.2.1: CB practice model **346:** For me, it was the structuring the sessions: with a start, middle and end gave an expectation that things would be done... **347:** I saw a tutor demo that showed that CBT could be done respectfully and not cold-hearted: the therapy relationship was important in CBT too. **349:** From CB skills practice, especially listening to each other's tapes: Reassured : we all struggled with similar issues. **351:** Really helping clients in my practice helped me. this was done collaboratively: e.g., writing conceptualisations for the client… 2.2.2: CB theory model: **343:** The overall approach of the CBT model was neat & coherent. The clarity of Beck's thoughts and the principles of the model. **345:** Well to be understand the conceptualisation mode: it took effort, reading and trying it before it fell into place.	2.3.1: CB practice learning **343:** Confused about groups, some wanted to use skill learning and some self-development: often meant nothing much got done. **345:** Difficult to adopt the structure…to confront issues… confrontation was something PCT saw as 'shock horror.' **346:** Previous courses had self-awareness work. Wasn't sure if that was supposed to happen in CBT training and this question seemed to divided trainees. **349:** My own stereotype of CBT as being very rigid got in the way of my learning for a while. It led me to kind of try too hard to 'be CBT'. 2.3.2: CB conceptual learning **347:** Conceptualisation became a 'hell hole' driving me bananas: it was jargon terms that put me off. **351:** I found the sheer volume to be learnt and covered quite scary at times. I'd have liked a longer period of study…	2.4.1: Successful **345:** Most of my work turned out well **347:** I found that it fitted me like a glove and that seemed to convey itself to clients so that things went pretty well most of the time, yes… **351:** Except for the first few times, when it got a bit tangled, the work went very well… 2.4.2: Mixed results **343:** It worked quite well but I had a longish period of time trying to decide whether to follow the CBT line or to do it my way. **346:** It went quite well but I got preoccupied with getting a tape for assessment – not the best way to learn. **349:** I had been struggling – but was starting to sort it about now	2.5.1: Good grasp of theory and practice **343:** I was over my little crisis. I had found my own way of doing it and my work had a very good solid feel to it. **345:** I began to feel that I had a good grasp of the model… I became of people claiming they were doing CBT but knew that they hadn't had my thorough training. **346:** I was definitely working in a different, more streamlined way… I was losing less clients and got more measurable change. **347:** My work felt richer… my ability to make therapeutic relationships had survived! I knew more 'tricks' to use… and I had preserved my sense of values about therapy… **349:** The whole thing was more relaxed: I thought, 'I can do this.' **351:** I felt more confident: using it more than I'd thought: At first, I thought I'd add techniques but now saw my practice changed.	2.6.1: Positive employer response **346:** I had been working on eating disorders in the voluntary sector and as a result of this training, I was invited to work in the clinical area. **347:** I'd had a voluntary post before the training but the qualification helped me to apply for a specialist clinical job: as a CB therapist actually! **349:** It didn't make any immediate difference but towards the end of the training, I'd decided I was going to apply for other things and I did get a specialist post in a staff stress service… I know the training helped me get the job. **351:** They announced it in the team meeting but otherwise no immediate difference… but then after a short while a new project arose (drug rehab for offenders) and they wanted people with CB knowledge… so I got the job! 2.6.2: Mixed They just seemed to be not very interested 2.6.3: Other **343:** The course was fairly irrelevant to the employers: I did the course for me.

CHART 6b: Trainees with a PCT preference on training experiences:

2.1: How did you feel at half way point	2.2: What did you gain most from CBT training?	2.3: What was most difficult in CBT training?	2.4: How did CBT work during training?	2.5: How would you sum up development end of training?	2.6: Employers' attitudes at end of CBT training
2.1.1: Generally favourable **353:** Really into it… Assessment went well… if anything, I felt that the course could push me more: feared being a 'keener'. **468:** Great. My first tape was okay… I thought, 'I can do this.' I had to get used to a lot (agenda etc.) CBT was a culture shock. **469:** Quite settled. I did a good tape: felt confident. I'd had a good report : all was going well. **2.1.2: Mixed feelings:** **356:** Very nervous about the assessment: theory foxed me: but shift to, 'Maybe I can do this.' **472:** Difficult to learn skills in set way. My brain went in 6 directions. **477:** Anxious about assessment: did I have the right client? I struggled with the structure. **595:** Fairly depressed, I'd failed for the 1st time for 15 year: I won't 'swan' through this, there I had to rock and roll.	**2.2.1: CB practice model** **356:** I liked practising and mastering CB skills and getting feedback: Disconcerting at first: losing what you had, not getting what you want. **472:** I really liked going into the separate areas such as depression and OCD – the applications of CBT. I 'd have liked to focus even more on that. Case discussions were helpful. **595:** I liked tools that CBT made available, some of the things I had been using innately, as it were. I'd identify cognitive distortions & use Socratic Dialogue to undo them. **2.2.2: CB theory model:** **353:** I found the theory so helpful… especially the way it took you to what the client might be feeling and thinking… it was almost like putting a tap on: You think, 'I have your internal dialogue here' and some access to things that might help. **468:** Though I struggled with it a bit, I found the idea of conceptualisation very, very useful… you know, to like make a map of the problem. **469:** A lot from conceptualisation, really looking into what the different parts of the problem were and thinking about how to address them. **477:** Before the course I'd thought that CBT was just about fixing things, conceptualisation was enlightening	**2.3.1: CB practice learning** **469:** The CBT imagery teaching was a bit confusing but it made more sense when I saw it being used with anxiety. **477:** I had trouble getting the right clients and my agency was anti and didn't encourage me to use it anyway. **595:** I soon realised that I had a big resistance to protocols and this made me very resistant to CBT. I later used protocols for ideas of things to try. **2.3.2: CB conceptual learning:** **353:** I thought that CBT theory was quick light in some respects… it doesn't have much 'critical perspective', things like race and gender… and these are big issues in psychology: especially in the type of urban area I work in. **356:** I felt anxiety about all there was to learn: if you were working with a client with anxiety, you had to understand a bit about anxiety: in PCT work, the approach was always the same, no matter what the problem. **468:** I did have some personal problems with things like having to travel long distances in bad weather but the biggest learning difficulty was putting concept into practice. **472:** I had problems with the structure we were supposed to follow: esp. how to fit conceptualisation to it.	**2.4.1: Successful** **468:** Yes, good results but not straight away… Had to sort myself out a bit… I had this big suitcase of forms **469:** The results were good and that was very pleasing to me… though clients were screened for suitability for brief work. **472:** The more confident that I got, the better the clients did, I think your confidence kind of spreads to them… **595:** Yes, the work went well, transforming I would say: but I only tried it with a few clients. I never intended to try it with them all. **2.4.2: Mixed results** **353:** Yeah, pretty well, most of the time: some clients were resistant, I was unsure if it was my inexperience or their stuff. **356:** It took me sometime to start getting any good results, for quite a long while, the feedback I got was mixed. **477:** I got mixed results, I think. Funny enough I got better results with the clients from the agency that was anti-CBT, they had lots of clients with anxiety and depression	**2.5.1: Good grasp of theory and practice** **469:** I had passed everything but still lacked a bit of confidence. I had to work with non-CBT people: I could now argue for CBT and stand my ground professionally **595:** Yes, I was confident by this time, I'd got conceptualisation and I kept a crib for the structure! **2.5.2: Quite a good grasp of theory and practice** **353:** I felt a slump at end: let down and disillusioned for a while. **356:** I felt quite reasonably confident but that I still had some things to work on… I have this thing about feeling confident in myself. Though I had passed the tape and I could see others had not. **468:** I was so angry with myself that I failed the tape: silly things that I forgotten to cover: but I knew it was a bad tape, it didn't stop me thinking that I could do it. **472:** My confidence was really starting to grow at this time but there was still some anxiety: I'd forget something. I carried a bag full of CBT stuff round with me. **477:** Pretty on top of: but there were things that I felt needed further time	**2.6.1: Positive employer response** **468:** I was so lucky that I had such a good motivating supervisor… she made sure that the management backed me and it all helped me get a much more secure clinical job **2.6.2: Mixed response:** **353:** The team were sweet but nothing from the management really… I was a bit cross - perhaps things will develop. **469:** There were a few well-dones but nothing much really (changed jobs to specialist drugs service later). **472:** Some congratulations but no more: I took the degree Cert. to personnel who copied and made no comment at all! **477:** Not very much change as yet… One employer did ask for CBT: that was because the boss is very anti-counselling! **2.6.3: Other:** **356:** It has made little change really. I didn't push them for much support or promotion because I want to feel free & without obligation **595:** They tolerated me doing this but had no interest in it. It was for me.

THEMATIC CHART 7: Trainees with psychodynamic preference on training experiences:					
What was your feeling at half way point in training?	**What was most gained from CBT training?**	**What was difficult about CBT training?**	**How successful when tried with clients?**	**How did you feel at end of CB training?**	**How did employer respond to completing CB training?**
2.1.1: Generally favourable **355:** I was enjoying it thoroughly. I got hooked on CBT quickly and lapped it up. I felt confident about the first tape and passed all the components on it… I found it all stimulating, despite a certain lack of confidence on the academic side. **480:** Apart from being terrified on the assessment side, I did think that I'd got the basic idea and that I could use it. I was quite excited. **2.1.2: Mixed** **361:** I was in my 'I don't think I can do this' frame of mind. I was over-focused on using techniques. My supervisor helped me to see this eventually. It wasn't all bad but it seemed jolly hard work: a very mixed experience at that point, I'd say.	**2.2.1: CB practice model** **361:** The structure was very helpful. It was good to be clear and write things down. I found it helpful to think about what homework might be helpful. **480:** Applications **2.2.2: CB theory model** **355:** I found the general CBT model to be easy to understand and use: for example, it could be applied to panic – I still use that a lot.	**2.3.1: CB practice learning** **361:** I had a tendency to react very negatively to the idea of CBT as 'prescribed treatment.' It made me resistant at times and I still think it is important to find my own way of doing it. **2.3.2: CB concept learning** **355:** I found the skills relatively easy to master but I really struggled with the academic work and all the writing we were required to do. **480:** I have always found it difficult to contribute in large group teaching situations… I worry about sounding stupid. I'd have liked a lot more small group work exercises to work theory and practice. There were some early on but they faded a bit as the training went on.	**2.4.1: Successful – no responses** **2.4.2: Quite successful/ Mixed.** **355:** Some responded well and some didn't… I think that I was over-using it in my initial enthusiasm… I got about a 50/50 response to that… **361:** It seemed to work pretty well… I was always keen to assess for suitability first… and that is something that I have stuck with as a practice… a good practice, I think… **480:** I favour careful screening actually… Some of my clients just didn't get CBT… it sounds awful, but I work with clients from the Valleys and they didn't seem to get CBT…!	**2.5.1: Good grasp of theory and practice** **355:** By this time, I had grasped it, yes… I had started to feel confident… I could talk the language by then. **480:** I was confident… a sign of this was that I knew what I was doing and *why* I was doing it. **2.5.2: Quite a good grasp of the theory and practice:** **361:** Well, I knew it wasn't seamless but I felt that it was 'good enough'. My style had certainly become more distinctive… I was able to be more upfront with clients and explain the rationale of what I was trying to do.	**2.6.1: Positive employer response** **355:** I was actually went into a new job as part of a primary health care team whilst I was still doing the course… CBT is a good approach for primary care so I know it helped me in there. **480:** Not much,… no, hang on, there were two employers who put staff counselling projects my way because of the CBT link. **2.6.2. Mixed employer response:** **361:** I was a bit disappointed in the lack of change but perhaps getting the CBT behind me did result in access to other types of referral and it may have helped me get the NHS job too.

TRAINING: INTEGRATIVE/ECLECTIC					
2.1: What was your feeling at half way point in training?	**2.2: What was most gained from CBT training?**	**2.3: What was difficult about CBT training?**	**2.4: How do you expect your CBT practice to develop?**	**2.5: Extent of professional engagement with CBT**	**2.6: Appraisal of impact of training:**
2.1.1; Generally positive: **357:** I'd had a good result on my assessment… Working in a hospice, I'd had a problem getting suitable clients but generally it was going well more than it wasn't, if you know what I mean. **473:** I felt quite confident… I had started the course later than the others but by this point, I felt that I had caught up on the skills but not perhaps on the reading… I'd been disappointed in my essay grade. **2.1.1: Mixed feelings** **360:** I failed items in my assessment and was naturally gutted…but… I thought that I would get there in the end with the CBT practice. I was more worried about the academic work: something I have always struggled with.	**2.2.1; CB Practice model** **473:** Lots but really the structure of it, writing notes, drawing diagrams and working in a very focused way. **2.2.2: CB theory model** **357:** Conceptualisation **360:** Conceptualisation	**2.3.1: CB practice learning** **473:** I found the small group work on skills difficult because I felt exposed at times, I'd have liked to have chosen whom to work with more. **2.3.2: CB practice learning** **357:** The speed, the pace of the way ideas was thrown at you: exciting in some ways but I felt like saying, hang on a moment, let me catch up there! **360:** I got the skills quite quickly but I found the academic work challenging in the extreme… it has always been a weak area for me but I was just determined to overcome it…and I did!	**2.4.1: Successful** **360:** In my situation, the clients are actually screened for CBT… so the work tends go well but I do find that I have to negotiate a bit with some clients… I am not like the behavioural people in my Unit, they are very hard line and don't concede to clients. **473:** It seemed remarkably helpful for clients… not all but mostly…. I do some of my work with Relate and they used to be a bit anti-CBT… now they will individuals for CBT but not couples… **2.4.2 Quite successful/Mixed** **357:** I worked in a hospice and not all the clients were suitable… but some worked well with it…my supervisor was a bit anti and that didn't help. Retrospectively, I think she was a bit threatened by my training…	**2.5.1: Good grasp of theory and practice** **360:** I'd say good but then I failed some items on the tape: I was perhaps a overconfident. I always felt better about the practice than theory, maybe my practice had got ahead of the theoretical understanding. **2.5.2: Quite a good grasp of the theory and practice** **357:** I had quite a good grasp of the model but that I still had some aspects to work on. **473:** I reckon that practice knowledge was good but I wasn't so sure about my theoretical knowledge but then I do have a personal issue there, doubting my thinking power and all that.	**2.6.1: Positive employer response** **360:** Employers were quite interested … paid some of my fees. There is a psychiatrist who is researching treatments for PTSD, including CBT. They gave me sessional work with him…interesting work… I'm probably looking to go even more specialist in time. **2.6.2: Mixed employer response:** **357:** I did actually get a very small rise … but that was the MA that did that. Other than that, nothing, a bit of resentment even. **473:** I got a little bit of personal congratulation and they do make some referrals for CBT that recognise my interest and skills in that area but that is all… so far!

6.3: The post-training phase:

The categories in the thematic charts relating to the post-training period were organised around themes that indicated the degree to which trainees had transferred their learning from the training course into their current practice situations. This involved distinguishing how they now referred to themselves and their practice. This question involved the act of defining terms for their current practice and examining why those terms were used. One trainee described a sense of 'converting' into CBT so that the training was 'supplantive' (Atherton, 1999). Others referred to a degree of increasing CBT practice effectively that had supplanted aspects of their practice, whereas others saw CBT training as 'additive' – adding extra dimensions to their current practice but leaving areas of other types of work intact. The development of practice was related to the extent they involved themselves in professional activities within the CBT professional community. Active involvement here implied strong post-training development of CBT but lack of active involvement did not necessarily imply that post-training development in CBT was weak. Exploration of perceptions of the impact of training were categorised around the width and depth of such engagement and these evaluations were often linked to perceptions of how CBT practice might develop in the future.

6.3.1: *Trainees with a cognitive behavioural preference at post-training:*

When asked whether they now called themselves CB therapists, these trainees largely answered in the affirmative and also often referred to a dynamic between self-description and description by others:

> Yes, most definitely… In my job, I'm called a 'counsellor' but I think of myself as being a cognitive behavioural therapist **(358/M/C15/CBT).**

> I am actually employed as a 'counsellor' but I think of myself as a cognitive behavioural therapist… it's a slightly tricky one… with titles you get into a status thing **(597/M/C15/CBT).**

The status issue referred to above implies advantage in the use of one term over another. This meant that some trainees had carefully considered how best to 'advertise' themselves:

> One of the first things I did was to get the words 'CBT' on my business card… It is also the way I advertise myself in Yellow Pages **(342/F/C15/CBT).**

Further questions asked trainees about the extent to which they use CBT in their current practice and how they saw their practice developing in the future. Most of

these trainees reported using CBT with many of their clients. Some gave percentage estimates that ranged between 50 and 100% of their current client workloads. Most saw the role of CBT increasing as time went on and some took the chance to record what they might like to happen or to speculate on which directions might be taken:

> I use CBT in about 80-85% of my work. The only situations that I wouldn't use it in would be in cases of bereavement and things like that... I haven't been able to get the sort of post that I would really like yet but I hope that when I do, CBT will be a predominant factor in my work **(476/F/C16-18/CBT).**

It is known that the effects of training may be lost through inertia and atrophy if the trainee does not keep up links with the subject area in the post-training period (Ashcroft et al, 1999). A key aspect of maintaining links with the CBT community was the relationship that trainees developed with BABCP, the UK national professional association for CBT. BABCP has an accreditation process, which is automatically endorsed by UKCP, the chief national body for psychotherapy. Completion of the course helped trainees to satisfy some of the criteria for accreditation by both BABCP and by the British Association for Counselling and Psychotherapy (BACP). BABCP has a journal and runs conferences and workshops on a local and national basis. The main themes in the answer to this question concerned whether trainees were current members, the reasons for and against either joining or being an active member, the extent of membership activities and the claims of 'rival' organisations. 16 of the 24 interviewees reported being current BABCP members – all 5 trainees with an initial CBT preference bar one were members – actually the same ratio of members to non-members as for the group as a whole:

> I am a BABCP member and do go to conferences and meetings. I like BABCP more than BACP (British Association for Counselling and Psychotherapy) – it's full of 'earth mothers'! When I deal with the NHS, I stress my CBT credentials **(342/F/C19/CBT).**

> I'm not in BABCP right now. I plan to put more energy into BPS (British Psychological Society) at this time. That could change later **(471/F/C19/CBT).**

The final question of the interview asked trainees to describe whether they thought that their view of CBT had changed as a result of training and also to assess the impact of the training on them. Changing views of CBT depended on what their original view of it had been. The biggest changes were reported by those who began with reservations about the model, most of which had greatly reduced after training. Most trainees reported that training had a big impact on them, their practice and their careers. For trainees with an initial CBT preference, though, there was less of a conversion effect and the impact of learning CBT was secondary to getting a higher

degree or to move towards professional accreditation, though both factors helped trainees to feel more competent and professional:

> I see CBT as more comprehensive... It had had a big impact on me and my confidence. I feel like I have the authority of the University behind me... I feel more professional and that shows in my work **(342/F/C17/20/CBT).**

> I saw it pretty much as I saw it before I actually admired some of he practitioners I have seen. I went in wanting to be more like them... (The training) had an absolutely huge impact professionally... but perhaps had even more of an impact on me personally... I feel like I understand a lot better now **(358/M/C17/20/CBT).**

In summary, the trainees who began the training with a preference for CBT were the most likely to now call themselves CB therapists. Even for them, however, there were questions about the legitimacy of using the title. They recognised that significant other people might define their work in other ways and that, for certain purposes these other definitions, rather than their own, would be officially sanctioned. They also describe a desire to expand their use of CBT and generally move towards more CBT oriented practice and professional engagement. They make clear that the training has had a big impact of their careers and lives but also suggest that that process began before the training

6.3.2: *Trainees with a person-centred preference at post-training:*

For the PCT trainees, the question about using the term 'cognitive behavioural therapist' to describe themselves evoked more ambiguous responses than amongst the other modality groups. They showed the same distinction between self and other definitions but were often less sure than the CBT trainees about what self-description they favoured now:

> It is hard to say about that. I would but my agency wouldn't... 'Counsellor' is a more acceptable term to them **(351/F/C15/PCT).**

> I use the term 'counsellor' but if I were doing private work, as I hope and plan to, then I would use the term 'CBT' **(356/F/C15/PCT).**

The issue of gaining advantage by using one term rather than another has meant that some PCT trainees have also considered how best to 'advertise' themselves:

> I call myself Integrative now. I'm in the process of designing a little business card ... and I'm thinking of putting CBT on it **(477/F/C15/PCT).**

Some found the issue of using the CBT title embarrassing:

> I can't say yes or no. I find it embarrassing... I may be underplaying myself, I think **(468/F/C15/PCT).**

A significant minority of the PCT trainees were genuinely undecided and, perhaps sensibly, were giving themselves time to consider their new situations and how they wanted to handle them:

> No, not really. I find it hard to get used to the idea of being CBT… I still use the term 'counsellor.' **(346/C15/PCT)**[5]

> Yes, I do use the term but it doesn't mean that much to me. It is what I do, not what I am **(347/F/C15/PCT)**[6]

> I think the honest answer is I don't know. Because I have thought of developing a private practice… I could call myself a CB therapist. Or am I more truly an integrative therapist now? **(595/M/C15/PCT)**

One way round this dilemma was to try a double barrel solution:

> That's a tricky one. Sometimes I do, well I'd say I'm a counsellor who does CBT. I am thinking about all that now – there's a status thing that goes with it **(472/C15/PCT).**

Interestingly, in the period since the interviews, two of the above interviewees, 346 and 347, have become BABCP and UKCP registered CB therapists. Perhaps, even at this stage, the PCT trainees were allowing their practice to run ahead of their claims about their practice status, certainly many reported that they were stepping up their CBT work by extending the range of clients with which they might apply CBT:

> I work with a majority of patients (as a counsellor attached to a health centre) using CBT, though not necessarily in a pure form… it has to fit in 6 to 8 sessions for a start… it could grow but I'm not in any hurry… there are other things I'd like to expand as well **(345/F/C16/18/PCT).**

> I have been using CBT with most clients (in a student counselling centre) for a while now. The students really like CBT but it may not be suitable for all… (Mentions client with cancer)… I am hoping it will grow… I am still reading round it **(472/F/C16/18/PCT).**

From employers, PCT trainees, like others, mainly got only small glimmers of recognition and there is a distinct sense of disappointment in the way this is reported:

> (I felt) a bit deflated really. I got my certificate… and took it over to give it to them (Human Resources). And someone in the Office said thanks. And that was it. I felt there should have been more… They still… don't value counselling… they still think it is tea and sympathy… **(472/F/B14/University counsellor)**

Some interpreted these signs of a lack of recognition as an indication that it was time to move on. Others achieved improved job status a little later:

> They announced my success in the staff meeting… but otherwise no immediate change… then they wanted CBT people and a graduate and I got the job of actually writing the programme **(351/F/B14/Drug agency counsellor).**

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[5] This trainee became a registered CBT therapist one year after this interview.
[6] This trainee also became a registered CBT therapist about two years after the interview.

Some had actually obtained jobs that carried a CBT label but even so were starting to consider what other styles of practice they might develop, perhaps showing a return to search amongst the whole range of therapies:

> Oh yes a lot. I am working at [a private hospital] and do individual and group CBT all the time… I do so much I can hardly imagine doing more… Actually I do see the value of doing other things… I am thinking of doing group analysis as my next 'thing' **(347/F/C16/18/PCT).**

In summary, the trainees who began training with a PCT preference report a more varied set of post-training developments. This may be partly due to the fact that trainees like the cohort of 346 and 347 were the first cohort in the study and so more is known about their longer period of post training development. The PCT trainees show less confidence about developing CBT practice but some of this appears to be a genuine diffidence about claiming the status of a CB therapist. There is comparatively little discussion of any on-going reservations about CBT but rather some reflection on how they overcame their reservations. It is clear that the outcomes of practice will be more varied in terms of the degree to which CBT is used for this group of trainees. This group seems likely to consist of some who will go into CBT practice in a major way whilst others, perhaps the majority, will continue to 'play with' their degree of engagement with it.

6.3.3: *Trainees with a psychodynamic preference at post-training:*

Trainees with an initial psychodynamic preference gave more decisive answers to the question of how to describe themselves as CB therapists:

> Yes, I put 'CBT' on my business card and 'counsellor' too **(355/F/C15/PSYDYN).**

> Yes, I put CBT on my business card as soon as I had passed the course. Some people did it before! … I also call myself a 'therapeutic counsellor' **(480/F/C15/PSYDYN).**

One of these trainees, had, moved some way toward CBT practice but wanted to make pragmatic use of such practice:

> If anything I now see myself as an integrated therapist… though I might stress my CBT credentials if I were talking to a doctor **(361/F/C15/PSYDYN).**

Estimates of how far they used CBT currently varied widely from 10% to 80% of clients. They also estimated that their views of CBT had shifted considerably but 2 of the 3 respondents, continued to describe reservations about the 'structured' aspect of CBT:

> My preconception that it (i.e., CBT) was very mechanical has gone because I have found that I can apply it in my own way. I am still a bit worried about the 'manual' approach **(361/F/C17/PSYDYN).**

The above trainee demonstrated that she regarded CBT as 'additive' to her practice so that it would remain to be based in the Psychodynamic approach as a first influence. She therefore aimed to keep the degree to which they practiced CBT steady at the current level and planned only limited engagement with the CBT community in future:

> The NHS would like to have more of my CBT and me but, to be honest, I don't find that an attractive option... I am a member of BABCP but my allegiance is more with BACP to be honest... CBT has turned out to be a useful tool in my tool-bag. It has made me acceptable to employers like the NHS and EAPs **(361/F/C17, C19 & C20/PSYDYN).**

Another trainee with an initial psychodynamic preference described her original preference for it as that of a 'true believer', she now refers to herself as a 'convert' and describes to her current involvement with CBT as likely to increase:

> It (i.e., CBT) will play a big role in the future.... I am a convert really... I am a member of BABCP and... I would say that the training has transformed my career and my practice. It has altered the way I think about all sorts of things, including my own life **(355/F/C17, C19 & C20/PSYDYN).**

In summary, in these 3 trainees we seem to see the full range of positive responses to training in a new form of practice. Using Atherton's (1999) terms, one trainee (355) had adopted a 'supplantive' approach to CBT training and was effectively converted into another model. Respondent 361 has adopted a clearly more 'additive' approach: she has retained her adherence to Psychodynamic theory and practice but has also made a pragmatic adaptation to CBT with a weather eye on current shifts in the perceptions of service providers and potential employers. The third trainee, 480, has probably made an adaptation between these other two points on the continuum. She has maintained a leaning towards Psychodynamic practice but has also developed an enthusiasm for CBT and, additionally has become a registered and accredited CBT practitioner. One might see this as either a stage of dissonance – holding two different ideas at the same time – or as a stage of maturity. She terms herself at the interview as 'Integrative' – a position sometimes held as one that transcends narrow school loyalty.

6.3.4: *Trainees with an Integrative/Eclectic preference at post-training:*

Trainees with an initial preference for the Integrative/Eclectic orientation showed a more pragmatic approach to the matter of how they now labelled themselves as

practitioners. Some answers show an appreciation of advantages that could lay in claiming different self-descriptions: though they could sometimes lead to conflict:

> Yes, I got told off about that (i.e., calling herself a CB therapist)... I think cognitive behavioural psychotherapy sounds posh! Some people in the NHS don't like that! **(360/F/C15/INTEGEC)**

Pragmatism was also evident in descriptions of how they decided if and when to use CBT as part of their Integrative/Eclectic practice:

> About 50/50 I'd say. It depends which environment I'm working in. I work in a hospice and I don't do much CBT there... I believe that CBT will always be there and I'd like it to develop. I'm interested in specific areas like social phobia... I'd like to do a workshop on that **(357/F/C16/18/ECINTEG).**

Although CBT training was seen as having been a highly significant part of their career development, it was seen as part of the development of a varied and wide range of practice, professional and educational elements, organised into a personal portfolio:

> I am not a member of BABCP. It is the money that stops me. I am a member of BASRT (British Association for Sexual & Relationship Counselling) ... that also offers a route to UKCP (United Kingdom Council for Psychotherapy) accreditation **(473/C19/ECINTEG).**

> I see CBT about the same as before I guess... The course had an enormous impact but I think that it more having the Masters that really does it for me... it is the MA that will have most effect on my career **(360/C17/20/ECINTEG).**

In summary, trainees who began the training with a preference for Integrative/Eclectic therapy show most similarity with the psychodynamic trainees in their descriptions of their post-training experiences. CBT training has had a clear impact on them and CBT has taken on an important role in their post-training practice. Once again, a degree of pragmatism is evident and CBT is seen as gateway into certain favourable positions in the current arena for therapy. These trainees most clearly articulated interests in other matters, such as rehabilitation work (357), research (360) and sexual and couple therapy (473). They seem to be developing a well-rounded portfolio of different professional skills within the helping profession and CBT has been an important new set of skills alongside their other skills.

6.3.5: Post-training summary:

In summary, the trainees all reported that CBT theory and practice still had a considerable impact on them at the time of the interviews, around one year after training. A range of different responses was evident in the answers to the question of how they termed themselves as therapists. The number of trainees prepared to declare

themselves as CBT practitioners showed an increase over the level of declared CBT preference at pre-training. It was also clear that there were some quite complex micro and macro political nuances to choosing a name and that these might run alongside or counter personal inclinations. Some trainees were still in the process of deciding how to handle these issues and it was clear that it is a process that may take several years to finally resolve. Others had clearly decided to limit any claims to being a CB therapist and to see any CBT that they might offer as mainly 'additive' to other therapeutic or professional skills.

The extent of the impact of CBT training on trainees varied between, on the one hand, seeing themselves as being full-on CBT therapists doing mostly CBT therapy with their clients and, on the other, seeing CBT as a useful arm of integrative practice and/or of wider professional skills. Most of the trainees kept up or planned to keep up contact with professional bodies promoting CBT in some way, though quite often at the same time as keeping up loyalties with other therapy organisations. Whilst a CBT dimension had been incorporated into the post-training profile of all the interviewees, there was also plenty of evidence of a healthy pragmatism: stressing the CBT 'credentials' when it was advantageous to do so, and stressing other aspects of theory and/or practice when it wasn't.

Chart 9: POST-TRAINING: CBT ORIENTATION

3.1: Do you call yourself a CB therapist?	3.2:Role of CBT in current practice?	3.3: Current view of CBT (compared to pre-training view)?	3.4: How do you expect your CBT practice to develop?	3.5 Extent of professional engagement with CBT?:	3.6 Appraisal of impact of CBT training:
3.1.1: YES **342:** It is on my business card and is how I advertise myself in Yellow Pages. It really is what I do. **358:** Yes, definitely. In my job I'm called a counsellor but I see myself as a CB therapist. **476:** Yes, I would and I wouldn't use any other term to describe my work. **597:** I'm actually employed as a counsellor but I think of myself as a CB therapist. The title is governed by a status thing. **3.1.2: NO** **471:** I do a lot of CBT but I still wouldn't use that term about myself.	**3.2.1: Use CBT with many/most clients** **342:** All the time, all the time. You can't offer it if you don't do it. **471:** I use in a lot of my work. **476:** In about 80-85% of my work. The only situations that I wouldn't use it would be in cases of bereavement and things like that. **597:** I'm using it a fair while. I wonder about it in certain situations: I have an OCD client who is pregnant and another guy who has cancer: not so sure how it fits in those cases. **3.2.2: With some clients:** **358:** I can't always do it in this job (employee counselling): sometimes they are just one of sessions. I'd like to use it more.	**3.3.1: See it differently:** **342:** I see it as much more comprehensive than I saw it originally. More positive but then I was pretty positive to begin with. **476:** I was surprised how much more there was to learn about it. I feel more positive but also as tougher to learn. **3.3.2: See it the same:** **358:** Pretty much the same. I went in wanting to be more like some of the CBT practitioners I had seen. **471:** No, not really, I see it about the same. **597:** No, I see it pretty much as I imagined it but I know it better now of course.	**3.4.1: Use of CBT set to increase/develop** **342:** I prefer CBT. There is still a stigma about counselling. Clients come to me for CBT. I do it 100% of the time with them but I'd like more clients. **358:** I'd like to do more. I am doing training in supervision and would like to get into CBT supervision. **476:** I have been having trouble getting a suitable post but I hope it will be a predominant factor. **597:** I expect it to grow in my practice and play a central role in my work. **3.4.2: Other:** **471:** I want to go for psychologist charter status. I'd like to specialise in a particular disorder. CBT might be part of that.	**3.5.1: Active engagement:** **342:** I am a BABCP member and go to meetings and conferences. I don't like BACP: full of 'earth mothers.' When I deal with the NHS, I stress my CBT credentials. **358:** I am a BABCP member and would like to get accreditation with them. **476:** I plan to get more active but I have been short of money at present. **597:** I have just contacted the local group in Swansea and am involved in efforts to get something going in Cardiff **3.5.2: Other:** **471:** I am not in BABCP at present. I plan to put more of my energy into BPS at this time. It could change later.	**3.6.1: Big impact:** **342:** A big impact: it has given me confidence. I have the authority of the University behind me. I feel more professional and it shows in my work. **358:** A big impact professionally, yes, but perhaps even more on me. I feel like I understand myself better. **476:** It has had a big personal impact, reinforcing my values and ways of seeing life. **3.6.2: Other:** **471:** Retrospectively, I now wish that I had continued on the BPS track but I would have done the training at some point. It has given me confidence. **597:** I'm pleased with the impact but I guess I still don't know where it is all going.

Chart 10a: POST-TRAINING: PERSON-CENTRED ORIENTATION

3.1: Do you now call yourself a CB therapist?	3.2: Role of CBT in current practice?	3.3: Current view of CBT (compared to pre-training view)?	3.4: How do you expect your CBT practice to develop?	3.5 Extent of professional engagement with CBT?:	3.6 Appraisal of impact of CBT training:
3.1.1: YES **347:** I do but the term doesn't mean that much to me. It is what I do, not what I am. **349:** Yes… I still believe in the therapy relationship but… it is part of CBT now, but perhaps wasn't 10 years ago. **3.1.2: NO:** **343:** Definitely not. I call myself a counsellor. I really like doing CBT but it will always be just one of the things I do. **3.1.3: Mixed response:** **345:** I do sometimes but more often as a 'counsellor': a counsellor who does CBT perhaps? **346:** No not really. I find that hard. I still refer to myself as a counsellor. **351:** It is hard to say about that. I would but my agency wouldn't, *'counsellor' is a more acceptable term.*	**3.2.1: Use CBT with many/most clients:** **346:** All the time, all the time, with all my work. It is my way of working now. **347:** Yes at the Priory I do individual and group CBT now. **349:** All the time, yeah. All the clients have taken to it well. **351:** I use it frequently. I was asked to write a CBT programme for the partnership. **351:** It is agency policy to use CBT on a regular basis and it is what I'd do anyway **3.2.2: With some clients:** **343:** I do CBT quite regularly but I don't necessarily start by thinking that I will do it. I get good results with it but I wonder if I would get better results if I did it in a purer form. **345:** I work with the majority of clients with CBT, though I wouldn't say in a pure form: it has to be in 6 to 8 sessions for a start.	**3.3.1: See it differently:** **343:** I came .to see that there was a lot more to it than my original image of it. **345:** I see it massively differently. My view was that it was very rigid but I realised that it could be adapted. **346:** I see it more positively, as a truly professional way of working. **347:** Yes, a big shift. I don't see it as cold and calculating now. **351:** A big positive shift. It has effected my practice much more than I thought it would. **3.3.2: See it the same:** **349:** The same really, but I understand it better and I realise it is not a magic wand.	**3.4.1: Use of CBT set to increase/develop** **346:** It will be throughout everything I do. Someone suggested I did a TA course and I thought, 'Oh no!' **3.4.3: Stay the same:** **345:** Well, it could grow but I am not in a hurry. There are other things that I want to expand as well. **349:** It has a big role now and will stay that way. **351:** I expect to stay in this job and as long as I do I will be doing plenty of CBT. **3.4.3: Other:** **343:** I feel unsure about that. I feel it will grow but it will be interesting to see how it unfolds. **347:** I do so much, I could hardly do more. I see the value of other things. I am doing some group analysis now.	**3.5.1: Active engagement:** **343:** I joined BABCP at the start of the training course. I am interested in accreditation and will probably go to conferences and meetings. **346:** I am in BABCP and I've been to some conferences. I am doing the accreditation now. **347:** I got the BABCP accreditation. **351:** I am a BABCP member and I'd like to get accredited. I haven't done any meetings yet but would like to if the times were okay **3.5.2: Other:** **345:** I did join BABCP but then I let it lapse. I lost money taking this job, even though I really wanted it, and some things just had to go. **349:** I haven't thought much about that: I am not a BABCP member.	**3.6.1: Big impact:** **343:** It has much more of an impact on my practice than I thought. **345:** Well it got me this job. Having the CBT training and the Masters gave me things that others couldn't offer. **346:** Does it sound too much to say it was life changing for me? I've been doing some work with obesity that feels quite ground-breaking. **347:** A very big impact. It got me a job with the title 'cognitive therapist' for a start. **351:** A big impact. It has increased my professional confidence **3.6.2: Other:** **349:** A major impact in that it led me to the job in (NHS) employee counselling.

Chart 10b: POST TRAINING PERSON-CENTRED ORIENTATION					
3.1: Do you now call yourself a CB therapist?	**3.2: Role of CBT in current practice?**	**3.3: Current view of CBT (compared to pre-training view)?**	**3.4: How do you expect your CBT practice to develop?**	**3.5 Extent of professional engagement with CBT?:**	**3.6 Appraisal of impact of CBT training:**
3.1.1: YES **468:** Yes, I think so. It it's such a big title. I called myself that before the MA but now I think I am worthy of it. **3.1.2: NO** **353**: That's difficult. My job title is 'counsellor'… that's the term I use but I do push CBT… a counsellor who does CBT **477**: I call myself Integrative now. I'm designing a business card now and I have thinking of putting CBT on it. **595**: I don't know… I'm thinking about it… not at present anyway. **3.1.3: Mixed response**: **356**: I use the term 'counsellor' at work. If I were doing private work, as I plan to, I'd say CBT. **469**: I can't say yes or no. I find it embarrassing… I may be underplaying myself. 472: That's a tricky one. Sometimes I do, well I'd say a counsellor who does CBT. I'm thinking about all that now – there's a status thing that goes with it.	**3.2.1: Use CBT with many/most clients:** **353**: Yes, I would say most. I'm now known as someone others can refer to for CBT. **356**: To a very large extent and more and more as tine goes on, I revert back to PCT less now. **468**: I use it all the time. The only time when I wouldn't use it would be with bereaved clients. **472**: I've been using it with most of clients for a fair while now. The students really like CBT but it may not be suitable for some (mentions client with cancer). **595**: I use it considerably – with the majority of my clients probably. Lots of my clients have given positive feedback (gives examples). **3.2.2: With some clients:** **469:** I can't use Beck at work – we have to use CORE. I do use CBT but in a more integrative way. **477:** I use it heavily – some use with most clients. I use the structure though I still don't say 'agenda'!	**3.3.1: See it differently:** **468:** Well, I see it as fitting my philosophy – more fully now. That's more positive and it is great to apply it. **477:** More positive – at the beginning I just saw it as a lot of techniques. There are techniques but they are rooted in conceptualisation. **595:** I know a lot more about it now. My first reaction was negative but now I would say that it is more positive. **3.3.2: See it the same:** **353:** I already saw it in a positive way so perhaps a small positive shift. **356:** I am very pro-CBT. I still see it as directive but I don't worry about that now. **469:** I know more but I still use it alongside other things too. My friends are sceptical of CBT. **472:** Well it was a fairly big shift. It was much more interesting than I expected. It has changed my practice more than I thought it would.	**3.4.1: Use of CBT set to increase/develop** **353:** I see it as increasing. It's a good career option, I reckon. **468:** Learning will carry on. I am going to the next Padesky workshop. I want to practice it more fully and inform others – that's my role. **472:** I am really hoping it will grow – I'm still reading round it. **3.4.2: Stay the same:** **469**: I hope so but I don't quite see how it is going to pan out yet. **477**: I'd like to do more work with organisations. I'm looking at solution focused therapy and think it is not so different. **3.4.3: Other:** **356:** I'd like to think it will grow but I'm not quite sure how yet **595:** I suspect that I will use it more and not just therapeutically but I'm thinking of going more into management and I reckon that I could use it there too.	**3.5.1: Active engagement:** **353**: I am a current BABCP member. Other team members are and we go to conferences together. **468**: My boss is pushing me to go for accreditation. I want to join a local group and will do conferences if they fit in. **472:** I am a member and I'm looking at the accreditation material right now. I am active in the student counsellors group but that is highly person-centred.. **3.5.2: Other:** **356**: I haven't joined BABCP yet but I am thinking about it and that is a big shift for me, I'm not a joining sort of person! **469:** I am not a current member. I've been to a Padesky workshop but that's about it for now. **477:** Not a member at present. I went to the Padesky workshop. May be I'll do more when I get more money. **595**: Probably not: I have other interests to pursue right now.	**3.6.1: Big impact:** **353:** As I have reflected now, I realise that it was a significant impact but of course now I am thinking much more about personal stuff. **468:** Positive: a huge impact. Just recently I thought to myself 'That was a big thing you've done!' **469:** Quite transforming – built up my confidence. I don't think a person-centred course would have done that. **472:** A big impact. I was actually on the point of giving up counselling … I felt so stale. Now I'm getting much better feedback from my clients and getting more satisfaction from what I do. **477:** On the whole a big impact – esp. on my practice. I hope it will continue. **3.6.2: Other:** **356:** Well it is hard to sort it all out. The CBT had an impact yes, but more was due to getting the Masters, I reckon. I just feel so much more confident about myself as a professional. **595:** I'm 58 so I am now thinking of changing to more clinical work sooner rather than later.

Chart 11: Post-training - Psychodynamic Orientation

3.1: Do you now call yourself a CB therapist?	3.2: Role of CBT in current practice?	3.3: Current view of CBT (compared to pre-training view)?	3.4: How do you expect your CBT practice to develop?	3.5 Extent of professional engagement with CBT?:	3.6 Appraisal of impact of CBT training:
3.1.1: YES **355:** Yes, I put CB therapist on my business card and 'counsellor' as well. **480:** Yes, I have put that on my business card – as soon as I passed the course. Some people put it on before! I also call myself a therapeutic counsellor. **3.1.2: NO:** **361**: If anything, I'd now see myself as an integrated therapist: though I might stress my CBT credentials if I was talking to a doctor! **3.1.3: Mixed response:** **No responses**	**3.2.1: Use CBT with many/most clients:** **355**: I would say that I use it about 80% of the time with clients. **480**: I'd say about 75% of the time. **3.2.2: With some clients:** **361:** Varies between 10 and 80%! Long term work use psycho-dynamic.	**3.3.1: See it differently:** **355:** I do see it differently, mostly because of having a much firmer grasp of it. **480:** There has been a big shift. I don't think CBT is cold as I feared before. I do take notes now but I still don't use a clipboard! It's okay as long as you explain what you're doing. **3.3.2: See it the same:** **361:** Yes and no. My preconception that it was very mechanical has gone because I have found that I can apply it in my own way. I am still a bit worried about the 'manual' approach.	**3.4.1: Use of CBT set to increase/develop:** **355:** It will play a big part in the future. I want to develop a CB approach with couples – that's my big interest **3.4.3: Stay the same:** : **361:** Well the NHS would like to have more of me and my CBT but, to be honest, I don't find that an attractive option. I enjoy being independent and organising myself on an ad hoc basis **480:** I'd like it to develop but I'm not sure if it will. I'd like to get involved in more specialised areas like OCD and using CBT there. We'll see how it goes. **3.4.3: Other:** **No responses**	**3.5.1: Active engagement:** **355**: I am a member of BABCP and read the newsletters and all. I don't really want to do any more study, so involvement would be balanced against time. I might be interested in accreditation if it wasn't too onerous a process. **480**: I am a BABCP member and I plan to go for accreditation. I really like BABCP, they are more responsive than BACP so I probably will get more involved as time goes on. **3.5.2: Other:** **361**: I am a BABCP member but my allegiance is more to BACP to be honest. I don't think I'll go for BABCP accreditation – at this point anyway but I might do workshops esp. if I do more work with the Psychology Dept.	**3.6.1: Big impact:** **355:** I would say that it ahs transformed my career and my practice. It has altered the way I think about all sorts of things, including my own life. **480:** It has had a huge impact not just on my practice but on the way I think about myself and my life. I expect the impact will go on into the future too. **3.6.2: Other:** **361:** It has turned out to be a useful tool in my tool bag. It has made me more acceptable to employers like the NHS and EAPs but I don't want to develop that much more anyway. I see CBT as a useful element to integrate into my work basically.

Chart 12: POST-TRAINING: INTEGRATIVE/ECLECTIC					
3.1: Do you now call yourself a CB therapist?	**3.2: Role of CBT in current practice?**	**3.3: Current view of CBT (compared to pre-training view)?**	**3.4: How do you expect your CBT practice to develop?**	**3.5 Extent of professional engagement with CBT?:**	**3.6 Appraisal of impact of CBT training:**
3.1.1: YES **357:** Yes, I have a business card and it says CBT on it. I don't always do CBT… I allow myself to do other things as well. **360:** Yes, I get told off for that: Cognitive Behavioural Therapist sounds posh. Some people in the NHS don't like it. **3.1.2: NO:** **No responses.** **3.1.3: Mixed response** **473:** Yes but then I blow it by saying that I am also a psychosexual therapist and an individual and couples counsellor!.	**3.2.1: Use CBT with many/most clients:** 360: When I'm doing psychological work, a lot of my work is CBT but some days I do psychiatric nursing. **3.2.2: With some clients:** **357:** About 50/50 I'd say. It depends on the environment. I do some work in a hospice and ~I don't do too much CBT there. **473:** It depends on the context really. I do some student counselling and there I do CBT all the time but in my Relate work, only in about 15% of the time.	**3.3.1: See it differently:** **357:** I'd see that as a big personal shift. At first, I thought 'Shit, I can't do this' but now I'm confident that I can. **473:** Well, I did have a positive view of it… I saw it as having huge potential but I just didn't see myself as doing it… that was the change. **3.3.2: See it the same:** **360:** No, about the same as I saw it before, I guess.	**3.4.1: Use of CBT set to increase/develop:** **357:** It will always be there and I'd like it to develop. I'm interested in specific stuff like social phobia – I'd like to do workshops on things like that. **360:** It will continue to grow, I think. There's a possibility of a funded research study and that would be 2 more years of CBT at least. **3.4.3: Stay the same:** **473**: I'd like it to grow but I'd have to get my act together and get more independent clients… there isn't that much scope in Relate. **3.4.3: Other:** **No responses.**	**3.5.1: Active engagement** **357**: I am a member and I'd love to do the accreditation **360**: I am a member and I am working towards accreditation. In an evidence based climate we have to do that sort of stuff now **3.5.2: Other:** **473**: I am not a member at present. It's the money that stops me. I'm a member of BASRT … that too offers a route to UKCP registration.	**3.6.1: Big impact:** **357:** Yes, a big shift. It has put my career on another footing. I feel more professional now. **3.6.2: Other:** **360:** Enormous, a big impact but is having the Masters that really does it for me and will have most effect on my career. **473:** Not small but big, somewhere in the middle, It could get big if I get my act together with the independent clients.

6.4: Developing a central thematic chart

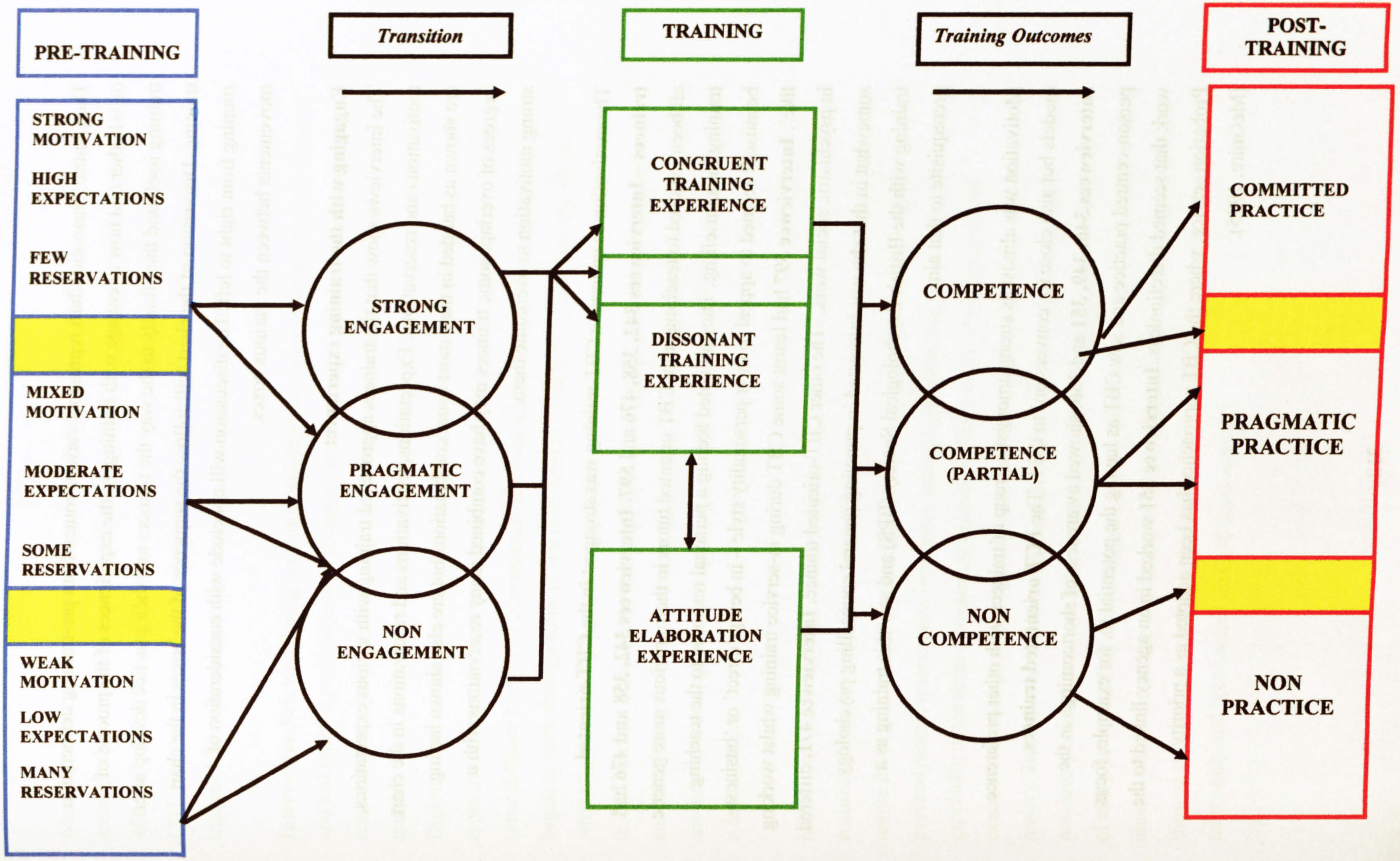
During data analysis, the author was struck by parallels between the research questions and the theory and practice of CBT itself. Central to the therapy is a process whereby an antecedent state is associated with a consequence via a mediating influence. Curiously, both the behavioural and cognitive arms of CBT have contributed a different type of 'ABC' analysis to CBT. Behavioural ABC analysis works on establishing a pattern of antecedent event – behaviour - consequences of behaviour (Sheldon, 1995). Cognitive ABC analysis works on establishing a pattern of antecedent event – belief - consequences (Ellis & Dryden, 1991). The parallels in my findings may be seen in the fact that the trainees began training with the antecedents of one set of therapeutic attitudes and behaviours, usually set within an occupational context, something happens in or during the training (mediating event) and often leads to the consequences of new therapeutic attitudes and behaviours.

The author therefore used an ABC format to construct the central thematic chart for Figure 6.1 with which to conclude this chapter.

The Central Thematic Chart shows typical stages in the preparation for CBT training, the experience of it and the outcomes that follow, as described by the interviewees in this study. A variety of responses are evident at each stage. Obviously, not all trainees show every response at each stage.

This final section of the chapter will begin by presenting the chart and then discussing its nature and showing how the movement of trainees through its various stages can be followed.

Figure 6.1: Central Thematic Chart: Experience and Process in Training



The Central Thematic Chart represents various routes from pre-training deliberation on whether and how to engage with training, to the experiences of the process of training itself and then finally to the way the trainees and their practice develop after training. Discussion of the chart will follow the sequence of the boxes in the chart running from right to left. The discussion will conclude with consideration of movements between the various boxes.

Engaging with the training experience:

The interviews show that the trainees approached training with various expectations, motivations and reservations. Expectations, motivations and reservations in the chart are shown as banded in their most usual combinations but are also shown having degrees of overlap: some trainees may have combined many reservations with a strong motivation to overcome them.

The motivation to undertake CBT training was strongest in the **CBT-oriented trainees – Interviewees 342, 358, 476** and **597. Interviewees 342, 358 and 476** had all been exposed to teaching from CBT oriented tutors in their previous more generic training in counselling. They all noted feeling a personal response to the teaching because it seemed to appeal to their personality style – in being 'direct' or 'business-like'. **Interviewee 597** had learnt some CBT during in-service training whilst working in psychiatric social work. The other CBT-oriented trainee, **Interviewee 471,** differed somewhat in that she was interested in pursuing general counselling psychology training with the British Psychological Society (BPS) and saw this training as a prerequisite to that aim.

Motivation was almost as strong amongst a group of trainees with other preference models but also close to 'conversion' to CBT. The **PCT orientated trainees, Interviewees 346, 349, 351** and **356,** showed awareness of shortcomings in the person-centred practice and saw CBT as having the potential to, for example, focus work that seemed directionless. **Interviewee 351** worked in an agency linked to the Probation service, where the CBT approached has been adapted as a priority (McGuire, 1995).

More mixed motivations and more reservations about the CBT model were evident amongst the other interviewees. PCT orientated trainees, **Interviewees, 343, 345, 353, 468, 469, 472, 477 and 595**, all mentioned the reservation abut the 'directiveness' of CBT. These reservations were qualified as being an issue of 'values' and the same trainees had a more pragmatic view of them as practice issues.

Interviewee 345, who during her initial training had 'fallen in love with Carl Rogers' and had rejected psychodynamic therapy, for example, mentioned that she did consider other options than training in CBT for her post-Diploma counselling training. The CBT option was available at the college in which she had completed her Diploma and was close to where she lived. Other options, included training in other types of therapy that might have been closer to her current values but were located some distance away. The convenience of a local course and the fact that she had begun to work through some of her reservations about CBT meant that she adopted what might be called pragmatic engagement with the training. Her motivation to train in CBT was not enhanced by her employers who regarded her as having undertaken enough training for her current role. By the time of the interview, she had moved into another work setting, counselling in primary health care, where CBT was regarded as a definite asset.

Mixed motivation and reservations were also held by the **Psychodynamic orientated trainees, Interviewees 361 and 480**. These reservations also concerned structure but, unlike the person-centred reservations that typically centred on structuring sessions, psychodynamic reservations were more focused on structuring interventions, especially in the form of treatment protocols. The resistance to protocols was exacerbated when protocols ignored interventions based on uncovering childhood history. **Interviewee 355** however entertained few reservations. She had been previously trained as a 'true believer' in Psychodynamic therapy. She was a therapist of many years standing and having just moved from another part of the country to the area, in which the course was based, well motivated for a change of therapy style. She showed strong engagement right from the start of training. She enjoyed the training thoroughly and 'got hooked on CBT fairly quickly'.

The **Integrated/Eclectic-orientated, Interviewees 357, 360 and 473,** had good expectations about learning CBT and reported few specific fears about integrating CBT into their practice.

Experiences of training:

The way interviewees described their experiences of training was characterised by three main themes: learning experiences; periods of confusion followed by attitude elaboration; experiences of academic and, particularly, skill assessment.

By and large these were characterised by responses that were mostly positive or responses showing mixed feelings. No interviewee showed a mostly negative response.

The **CBT oriented trainees** tended to report the most positive responses to training and because they began holding the same paradigm as they were taught, they did not report many attitude elaboration experiences. They also reported mainly doing well in assessment. **Interview 342,** for example, referred to the fillip of confidence that came from realising that she had performed "above average" in the mid-course skill assessment. Only one interviewee in this group, **358,** reported failing a skill item and even then in the context that he realised that he could do the therapy and was therefore confident about re-assessment of this item. One CBT-oriented respondent, **Interviewee 471,** did report feeling some anxiety about assessment, but this arose in the unusual context of two tutors apparently disagreeing about an aspect of her work.

In contrast, the **PCT-orientated trainees** reported many more mixed experiences of both training and assessment. The fears about not being able to square CBT with person centred values were particularly stressed, especially during the early phases of training. **Interviewee 349,** for example, described a series of doubts that she had to work through, as did **Interviewees 343, 345, 353 and 477.** On the other hand, these doubts were often coupled with a sense of growing confidence in the second half of training, as mentioned by **Interviewees 347, 351, 468, 469 and 472.** The theme of a lack of confidence about both the self and in relation to learning CBT was strongly represented amongst these trainees and **Interviewees 356 and 472** both mentioned a lingering sense of self doubt even after successfully completing skill assessments. Given that lack of confidence was a strong issue with this group of trainees, it is not

surprising that frequent mention of anxiety about assessment is also made – for example, by **Interviewees 343, 346, 356 and 477.** Even a very confident trainee such as **Interviewee 595** reported anxiety when he failed some items of the mid-course assessment – the first time that he had failed anything for many years. He wisely concluded that he would not be able to 'swan through' this training.

Of the **Psychodynamic and Integrated/Eclectic oriented trainees,** only **Interviewee 480** reported being anxious, indeed 'terrified' of assessment. These trainees were more likely to report difficulties with academic work, as did **Interviewees 355 and 360. Interviewee 361** reported a phase of thinking, 'I can't do this' and considered leaving CBT training. As she passed all her skills assessments first time, this anxiety was more likely connected to reservations about CBT principles. She reported discussing these with her supervisor, who advised her to take the pragmatic position of putting her reservations to one side and see what she could find of help in CBT. This she resolved to do.

Attitude elaboration processes

Attitude elaboration processes were not evident amongst **CBT-oriented trainees** but were particularly reported by the **PCT-oriented trainees**. The most detailed descriptions came from **Interviewee 343** and have already been described in Section 6.2.2. Such processes were also evident in the accounts of **Interviewees 347, 477, and 595.** Many PCT trainees had strong reservations about whether CBT contravened the principles and values of 'non-directive' therapy advocated by the Rogerian model.

Interviewee 347, a trainee who began with and stuck to PCT values, describes an interaction with a tutor in which she re-examined and then reframed the meaning of 'non-direction'. **Interviewee 351** describes coming to a similar realisation herself by coming to see that CBT was 'not over-directive' and that, after all, it did not advocate 'going in there with hob-nail boots on.'

Amongst the **Psychodynamic-oriented trainees,** the concepts of CBT made sense to **Interviewee 355** and she began to quickly make use of the basic CB model on the relation between thoughts, emotions and behaviour. She was then able to use that model to explain to clients what underlying factors might be driving the panic attacks

they experienced. As well as these training experiences that were congruent with her expectations, she also had dissonant experiences when the model did not seem to fit for some clients. She began to realise that she was over-applying the model and that this was partly because she still had much to learn about using it. She was able to step back from this type of over-application through a process of elaborating, discussing and reformulating her original attitudes to practice through case discussion, supervision and generally sifting through the concepts and methods that she was learning. In contrast **Interviewee 361** held reservations about CBT and made a more pragmatic adaptation to learning it.

A more pragmatic approach to learning was also evident in the **Integrated/Eclectic oriented trainees, Interviewees 360 and 473** – both of whom had strong career agendas in other directions - the former as an experienced psychiatric nurse and the latter as a sex therapist. The other trainee from this group, **Interviewee 357** had come into training from a business career and saw that learning CBT was helping to convert into more of helping professional.

Attitudes reflecting reservations about CBT do seem to have some ability to delay competence acquisition and perhaps other training outcomes. The biggest specific clash that was detected amongst the trainees in this study was that between an aversion of being 'directive' and mastering the skills of 'setting an agenda'.

Interviewee 477, a trainee with an initial PCT preference, describes evolving a mantra – 'I must set an agenda, I must set an agenda!' - to say to herself as she went into sessions to help her overcome this tendency.

It is interesting that very few trainees reported any problems about setting homework, though this may be regarded as another form of agenda setting – but one that comes at the end of a session, when perhaps both trainee and client are in more attuned interpersonal contact and are therefore more relaxed. The main fears of PCT-oriented trainees in CBT are, firstly, that being overly directive may make the therapist seem like an over-bearing 'expert', and, secondly, it could disrupt a trusting and collaborative therapeutic relationship between therapist and client.

Experience in the post-training stage:

Data from the post-training phase of the interviews was characterised by themes relating to how trainees adapted their practice and professional identity after CBT training. A key question concerned what they would call themselves and their practice, obviously turning on the degree to which they should feel inclined to use the term 'CB therapist' of themselves and/or 'CBT' of their practice. Most trainees in this sample had previously regarded themselves as 'counsellors' and this offered a compromise label – 'a counsellor who does CBT'. Duality is also evident in the way trainees describe the balance of their practice, most saw plenty of space for CBT but many were also anxious to have space for 'other things'. It might be thought that even though many stressed the market advantages of CBT, there would also be advantage in being able to offer other things. There was also duality in the way trainees thought about themselves and how they thought others thought about them – some retained the external label as 'counsellors' but now clearly regarded themselves as CB therapists. Five of the interviews, 342, 346, 477, 353 and 480 described redesigning their business cards to accommodate changes of label. The extent of an emerging CBT professional identity was also evident in the degree to which trainees connected with the CBT community, via the professional association, BABCP, conferences or supervisory activities.

The **CBT-oriented trainees,** such as **342** and **476** were the most firm in claiming the title of CB therapist. **Interviewees 358 and 597** had jobs title as 'counsellors' but clearly saw themselves as CB therapists. **Interview 471** was once again the maverick in this group. She did not call herself a CB therapist and continued to aspire to the status of counselling psychologist via BPS accreditation. She was not a member of BABCP, whereas **Interviewee 342, 358 and 597** were and **476** intended to join as soon as finances allowed.

For **PCT-oriented trainees,** post-training practice and professional stance were influenced by the extent to which initial reservations about CBT training have been worked through and also by the relative smoothness with which CB competence is attained. Good experiences tended to lead to practicing CBT and becoming engaged with various professional group activities such as association membership, pursuit of accreditation and conference going.

Interviewee 346 began training with a PCT stance but at the time of the interview she was on the brink of accreditation as a CBT therapist. This was partly a 'conversion experience' but it was a conversion experience that had been rewarded by substantial pragmatic and career gains: '... a higher degree and maybe get some work... Wow, nice one!' as she put it so succinctly. Indeed trainees who were looking for new employment seemed to find it easier to find recognition of their CBT status than did trainees who were trying to appraise their current employers of the same fact.

Similar patterns were evident amongst **Psychodynamic-oriented trainees.** The 'conversion' experience of **Interviewee 355** has already been referred to. By way of contrast, **Interviewee 361,** reported herself as 'Integrative' at follow up interview, had attained competence without undue difficulty and saw some advantages of wearing a CBT badge as far as certain employers might see it, but maintained only a pragmatic commitment to CBT and, like others, might vary how she describes her work according to whom she is talking to: 'I might stress my CBT credentials if I were talking to a doctor.'

The Central Thematic Chart is a useful device for conceptualising the various elements of how the interviewees in this study described their engagement with CBT training at different stages in the process. There are recognisable patterns through these stages, ranging from passing from expected strong commitment to realised strong commitment, through to expectation of pragmatic commitment to realised pragmatic commitment, and, points between. It is also likely that different types of trainees make different types of journeys. Some trainees particularly may want to address some key issues – such as the therapeutic relationship in CBT – and how they do this may influence how they proceed.

Some possible pathways between the stages were not evident in the interviews - no trainees described following pathways from weak engagement to non-practice. This is probably because trainees following such a route were a small minority and were less likely to participate or be interviewed in the study. A psychodynamic-oriented trainee, **Interviewee 361,** did however mention that the dissonance problem had been so great for her that at one stage she contemplated leaving the course and was only dissuaded

by her external clinical supervisor. Another trainee who was not interviewed because she was still doing her dissertation did tell me that she had a major crisis during the course when she felt that she could not resolve her reservations about CBT. She dealt with this situation by going 'off sick' from the course for about a month and seriously contemplated not returning. She did, however, succeed in working though her reservations and eventually made a successful return to complete the course.

The processes described by the Central Thematic Chart are probably generic ones that may apply to many types of learning situations: some of them match those described by McKay et al (2001) in their qualitative study of counsellors changing existing models to learn interpersonal dynamic therapy).

Pathways of change through the stages:

Psychological therapy is often described as being predicated on change (Horowitz, 2005) and training for psychological therapy assumes changes in the trainees' attitudes and behaviours, though some will always resist change. Change and resistance to change are frequently mentioned in the interviews. Looking at Figure 6.2, we can see evidence for both. There are some changes in colour from pre to post training stages, yet many trainees retain their original allegiances. Looking at the trainees who report having changed, one is reminded of the 'swing voters' who frequently seem to decide elections (Dalton, 2006). In this 'election', where after all one party had all the campaign expenses and a favourable position that outweighed all others, most of the floating vote has gone towards CBT (346, 349, 351, 356, 468, 355, 347, 472, 480 and 357) but there are also some pleasingly 'local' results: 477 changed from PCT to Integrative, 361 from Psychodynamic to Integrative, and, finally, 471 changed from CBT to Integrative. The allegiance change of 361 indicates that all psychodynamic-oriented trainees did actually change allegiance in some way. This is perhaps because the well known and well rehearsed differences between the two models would mean that anyone contemplating training in the other model was certainly contemplating change.

Figure 6.2: Pathways through training:

BAND A: Very strong initial engagement:		**Generally positive training experience:**				**CBT Professional identification:**	
342[8]	>	>	>	>	>	>	>342
358	>	>	>	>	>	>	>358
476	>	>	>	>	>	>	>476
597	>	>	>	>	>	>	>597
BAND B: Quite strong initial engagement:		**Generally positive training experience + successful attitude elaboration:**				**CBT Professional identification:**	
346	>	>	>	>	>	>	>346
349	>	>	>	>	>	>	>349
351	>	>	>	>	>	>	>351
356	>	>	>	>	>	>	>356
468	>	>	>	>	>	>	>468
355	>	>	>	>	>	>	>355
BAND C: Ambivalent initial engagement		**Ambivalent training experience + successful attitude elaboration:**				**CBT Professional identification:**	
471	>	>	>	>	>	>	>471
347	>	>	>	>	>	>	>347
472	>	>	>	>	>	>	>472
480	>	>	>	>	>	>	>480
357	>	>	>	>	>	>	>357
BAND D: Ambivalent initial engagement		**Ambivalent training experience + partial attitude elaboration**				**Non-CBT Professional identification:**	
343	>	>	>	>	>	>	>343
345	>	>	>	>	>	>	>345
353	>	>	>	>	>	>	>353
469	>	>	>	>	>	>	>469
477	>	>	>	>	>	>	>477
595	>	>	>	>	>	>	>595
361	>	>	>	>	>	>	>361
360	>	>	>	>	>	>	>360
473	>	>	>	>	>	>	>473
ENGAGEMENT		**TRAINING**				**POST-TRAINING**	

[8] Numbers in red indicate CBT trainees, in green PCT trainees, blue Psychodynamic trainees and purple Integrative/Eclectic trainees.

Chapter 7: Conclusions

7.1: Introduction

This chapter begins by restating the context and background of the study. It continues by offering a brief summary of previous studies and then shows how the author was able to identify the gap in these studies that this study sought to address. The chapter then offers a brief resume of the main results of the study, followed by consideration of the limitations of the methods used in the study.

The chapter then considers the implications of this work for further research and policy. This involves examining the reliability and validity of the data collected by the study and the extent to which the results of the study might be generalised to other populations and contexts. The chapter concludes by offering some reflections on the implications of the study for training in CBT.

7.2: The Context of the Present Study:

This was a longitudinal study of 3 successive annual cohorts of trainees who enrolled on a voluntary basis to undertake training in cognitive behaviour therapy (CBT). CBT is one of the four main broad schools of psychological therapy available in the UK and other countries. It was preceded by psychodynamic therapy, coming from the Freudian tradition, and by person-centred therapy (PCT) from the humanistic tradition. Integrative/Eclectic therapy attempts various combinations of these other traditions and emerged about the same time as CBT. The four broad schools share some ideas and methods but also have distinct points of difference. There has been a history of competition and co-operation between these four broad schools. Conflicts between them have ebbed and flowed over the years. A degree of conflict between CBT and the other traditions has occurred in recent years as CBT has been accorded increased status as the UK medical profession has promoted claims for the efficacy of CBT – claims that other approaches have found hard to match.

The current policy proposals, initiated by Lord Layard, to increase the UK provision of psychological therapy in general and CBT in particular (Linklater, 2005) have naturally been resisted by the other approaches, though it has been difficult for them

to formulate a policy as they themselves may stand to make some gains from expansion of services.

The division between different schools has been exacerbated by the fact that they tend to have separate professional and training organisations, though there are also organisations, such as British Association for Counselling and Psychotherapy (BACP), the British Psychological Society (BPS) and the United Kingdom Council for Psychotherapy (UKCP) that try to unify national standards.

Training in psychological therapy may become one of the arenas in which the differences between models may make themselves felt. Trainees have first to decide what kind of training will be best for them and then whether such training is conveniently available. Sometimes trainees will find that a training course is based on a set of ideas different to those that they are already familiar with. These differences in ideas and methods may lead to complications in training. Usually, however, trainees are quite well aware of these differences and will select themselves out of situations where they estimate that differences in ideas may prove problematic for their progress. Sometimes, however, other factors, such as locality, cost or convenience, may not allow them to select their ideal course.

Another thrust in recent government policy, actually a forerunner of the Layard initiative already mentioned, has been the promotion of evidence based practice in many professional activities, but most germane to these concerns, in psychological therapy (Parry & Richardson, 1996). The thrust of evidence based practice is that practitioners should be aware of what the current evidence says about various treatment options and should seek to implement or at least refer to the best treatment for the most suitable patients. This is by no means as simple as it sounds. Keeping up with research findings is an arduous task, especially for the practitioner with a busy everyday work load. Professionals in many fields are known to struggle with keeping up to date with research in their fields and psychological therapists have been no exception (Persons, 1995). Research findings are often hard to interpret and may be open to different interpretations. An appropriate referral source for an indicated treatment may be hard to find. CBT treatment, for example, features strongly in the efficacy literature but is in short supply and suffers from uneven geographical

distribution (Shapiro et al. 2003)[1]. For an individual practitioner, it would be difficult to span all the methods that might be needed to provide an effective service according to these criteria. Finally, therapists from the different traditions often do not accept the evidence base for other traditions and may want to rewrite the rules about what sort of research gives the truer picture. Some have even argued that 'evidence-based practice' should be replaced by 'practice-based evidence' (Mellor-Clark, 2004).

These professional politics do impact on the choices that trainees have to make when considering what sort of training to pursue. In the interviews conducted for this study trainees often referred to a perception that CBT was the 'coming thing' and that government services, especially in the NHS, were taking on CBT as a treatment of choice. For some trainees, who in any case leaned towards CBT theory and practice, this seemed very serendipitous, especially when they had access to a training course near to their homes – at the time of the cohorts in this study, there were only 15-20 such course centres in the country. For those trainees who leant in other directions, a local course in CBT might have still seemed quite serendipitous, in that it might allow CBT to be attached to the trainee's portfolio and lead to a higher degree into the bargain. In making a calculation about whether to sign up for such training, a trainee needed to make an assessment of likely gain as against likely loss.

There is a discourse within psychotherapy outcome research that argues that there are no significant differences in outcome between psychotherapy models - the 'Dodo bird verdict' (Luborsky et al, 2002). Not all agree with this line of argument (Hunsley & Di Giulio, 2002), especially advocates of CBT (Chambless, 2002). The argument that the main models of psychotherapy have equivalent effects is an influential one in the therapy world and might encourage trainees to disregard, or at least make light of any differences they might have with the therapeutic paradigm that they might be expected to absorb in a particular type of training. In a nutshell, this discourse declares that therapeutic outcome is most influenced by 'common factors' mainly connected to the therapeutic relationship. It is further argued that therapeutic technique is not important, does not contribute much to outcome difference, and that therefore all therapies are equally effective. In a conclusion that conveniently

[1] Shapiro et al (2003) report that there were 602 accredited CB therapists in England & Wales in 2003.

downplays inter-professional rivalry, this discourse ends by suggesting that 'Everyone has won and all must have prizes' (Luborsky et al, 1975). Thus trainees may have hoped that CBT techniques could be added to their current repertoire of skills in some form of integrative practice, either of an eclectic type or by combining particular models, such as PCT with CBT, or Psychodynamic with CBT. How far trainees thought they could 'live with' CBT practice might depend on exactly what therapeutic attitudes they currently held and how strongly they held them. Many trainees in this study did hold attitudes about therapy that were at variance with CBT principles but saw the move into CBT as low risk because any gap was not that wide. Others worried that the gap might prove too wide and agonised about choosing to do CBT training. Self-evidently the trainees in this study eventually decided that the risk was worth taking – though it was a closer decision for some than for others. One might expect, however, that undertaking a type of training whilst holding reservations might affect learning in some way, perhaps adversely.

7.3: Previous studies:

There has been a good deal of literature and studies on the role of orientation in psychological therapy (Dryden & Mytton, 1999; Goldfried, 2000) but not much of it has centred on training. Most of the studies of training have been of comparatively recent origin. In one training study, not about CBT training, Mackay et al (2001)[2] examined how a group of person-centred counsellors tried to 'change models' by learning Interpersonal dynamic therapy. This study focused on the difficulties experienced by trainees as they attempted to do this. Although the study was concerned with a different set of attitude changes than the one in this study, the trainees reported some of the same sense of difficulty in changing attitudes. Some also mentioned the difficulty of 'trying too hard' to take on the new model and thereby blocking the development of actual learning.

Persons et al (1996) described the reservations about CBT reported by trainees with a psychodynamic background as they undertook CBT training. This was a qualitative report that focused mainly on describing theoretical and practical reservations about CBT. For example, a major reservation was that attempts by CBT to alleviate

[2] See Chapters 3 & 6.

symptoms, rather than as psychodynamic therapists might try to uncover and 'work through' deeper conflicts, was like putting a sticking plaster over a wound that required surgery. Persons et al (1996) also suggest that these reservations about CBT can be overcome during training and they suggest a mechanism for doing so – namely, by encouraging trainees to surface their reservations, discuss them and then to try CBT methods in a gradual and experimental way. The process of surfacing and discussing reservations may be likened to the way problems of cognitive dissonance are dealt with in training (Atherton, 1999). One way of resolving dissonant attitudes is described by Petty & Cacioppo (1986) as an 'elaboration likelihood' process, and is advanced as a process likely to promote lasting shifts in attitudes. Petty & Cacioppo (1986) argue that peripheral attitudes can be changed by persuasion whereas centrally important attitudes can only usually be changed by an attitude elaboration likelihood process. Heersacker & Mejia-Millan (1996) have argued that these processes are well placed to explain client change in psychological therapy but the analysis has not yet been applied to training in psychological therapy, as far as I have been able to ascertain. Persons et al (1996) imply that many of the trainees in their study do resolve their ambiguous attitudes towards CBT but they do not describe how they derived their data about this and they do not describe any outcomes of this training in terms of skill or knowledge acquisition.

Knowledge acquisition during CBT training was described in the study by Freiheit & Overholser (1997). They studied the responses of 3 annual cohorts of US clinical psychology trainees coming from a variety of model preference positions to training in CBT. They measured their therapeutic attitudes and their knowledge levels pre and post training. They found that trainees from different model perspectives learned the model in similar ways and reported roughly similar changes in their practice. Freiheit & Overholser (1997) did not, however, include any assessment of CBT skill acquisition in their study. They commented that future studies should include analysis of skill acquisition.

Morgenstern et al (2001) studied how a group of drug counsellors, mainly following the AA twelve step model, responded to CBT training. They found that trainees were mainly able to transcend their previous model base sufficiently to be able to learn CBT concepts and skills. These findings were, however, quite specific to the context

of drug counselling and the study used a drug work specific measure rather than the usual and standardised skills measure used in CBT training, the Cognitive Therapy Scale (Young & Beck, 1980, 1988; Milne et al, 2001).

The study described in this thesis therefore built on these preceding studies and included all their major elements, overcoming the limitations of previous studies in which one element or another had not been included. It explored the attitudes of 3 cohorts of CBT trainees, from a variety of practice settings and model perspectives, by administering questionnaires and by conducting semi-structured interviews with them. Interviews also focused on trainee perceptions of how successful they had been in overcoming their reservations during training. The CBTTQ questionnaire contained an inventory, the Cognitive Behavioural Principles Inventory (CBPI) that was found to have strong internal consistency and allowed the development of therapeutic attitudes of trainees to be tracked from pre-training to one year post-training follow-up. The study also measured the development of their acquisition of CBT skills, using the Cognitive Therapy Scale-Revised (CTS-R: Milne et al, 2001) at pre, mid and end of training. The methods of the study, as described in preceding chapters were transparent and clear. The data collected by these methods allowed examination of research questions focused on describing the development of therapeutic attitudes, CBT skills and the interaction between these two factors. Interviews also allowed trainees to reflect on the training process, including on factors that seemed to help or hinder them in attaining their various goals.

In summary, previous studies on CBT training with trainees with non-CBT therapeutic attitudes stressed that attitude differences could be overcome by the training process, though they have sometimes made light of the differences and have tended not to describe how trainees resolved difficulties that might arise from them. Persons et al (1996) described psychodynamic reservations that are founded in deeply held attitudes. Persons et al (1996) implied that such reservations may be overcome but does not say how. In contrast, discussion in this study has focused more on the reservations of person-centred counsellors, mainly because of their predominance in the counselling field. It also describes their reservations about CBT in depth. Additionally, the interviews offered the trainees an opportunity to describe the extent to which they had resolved their reservations and how they had achieved this. The

story that emerges has similarities to the findings of Mackay et al (2001) in relation to training counsellors in psychodynamic interpersonal therapy. Additionally, this study has focused on CBT competence development. Only one other study, Morgernstern et al (2001) included competence ratings, and they used a measure specific to working with alcohol problems. Morgernstern et al (2001) did not make precise and focused links between attitude and competence development. In contrast, this study makes specific links between certain therapeutic attitudes and the execution of specific skills and is therefore able to make recommendations about how tutors can identify and work with task-interfering attitudes that may delay competence acquisition for trainees in CBT.

7.4: A resume of the main results of the study

The data in this study was collected to answer four research questions:

- What attitudes do trainees entering a CBT training course hold towards CBT practice principles and how do these attitudes develop during training and in the year following the end of training?
- With what level of pre-existing competence in performing the skills associated with CBT practice do trainees enter CBT training and how do these CBT skills develop during training?
- What kind of association and influence do model preferences and the attitudes towards CBT principles held before and during training have in the development of competence in skills associated with CBT practice.
- What characteristics of CBT training and development do CBT trainees report as being most likely to lead to the resolution of difficulties in learning CBT during training?

It was hypothesised that trainees would hold different sets of therapeutic attitudes, some of which would be likely to be difficult to square with CBT attitudes. It was also hypothesised that CBT- incongruent attitudes would cause some difficulties in learning CBT skills. Finally, it was hypothesised that, as adult learners, trainees would respond to some aspects of experiential and self-directed learning, combined with structured learning of skills and techniques.

The CBTTQ data showed that the trainees in this study began with a variety of model preferences and that only a small minority, 14%, of the trainees began with a preference for CBT. Almost half the trainees - the largest model preference sub-group, preferred Person-centred therapy (PCT). The next largest sub-group was that of 26% of the trainees who preferred an Integrative/Eclectic model. Only 12% preferred the Psychodynamic model. In the questionnaire and interviews many of the PCT and Psychodynamic trainees showed that they began training with significant reservations about CBT theory and practice – especially connected to the structure used in CBT, the fact that CBT promoted behaviourally focused goals and CB therapy aimed to achieve these goals in relatively time circumscribed interventions.

Although most of these PCT and psychodynamic trainees modified these reservations and attained CBT competence over much the same time scale as other trainees, a minority, especially of trainees with initial PCT preference, found the transition more difficult and were slower to attain competence – in some cases requiring extra periods of assessment to retake modules in the following academic year. Trainees who began by preferring CBT showed strong and growing agreement with CBT principles over the period of training and were the model preference group that proceeded to competence most quickly. Psychodynamic and Integrated/Eclectic trainees took intermediate positions between the CBT and PCT groups in both growing agreement with CBT principles and the acquisition of CBT competencies.

Analysis of the acquisition of the skills of CBT identified by the CTS-R (Milne et al, 2001) showed that trainees in this study generally moved quite quickly towards overall competence. Thirty-two of the 55 trainees, 58% of them, demonstrated overall competence at the first opportunity. A further 11 of them, 31%, achieved competence by resubmitting for further assessments. The remaining 6 trainees could retake modules by enrolling in the following academic year. All 6 trainees were able to do this successfully but this meant that they had taken twice as long to achieve competence than those 32 trainees who had demonstrated overall competence in CBT skills at the first opportunity. Five of these 6 trainees began training with a PCT preference and one with a psychodynamic preference. The mean training completion times for PCT trainees, 11.54 months, and Psychodynamic and Integrative/Eclectic

preferences, 10.71 months, were longer than for trainees with CBT model preference, 9.38 months, though these differences were not statistically significant.

Analysis of individual CBT skills, as defined by the CTS-R, showed that it was more difficult for trainees to acquire competence in some skills than others. Pre-training analysis of skills showed that trainees did arrive at training already able to demonstrate competence in some of the skills associated with CBT. The CTS-R distinguishes between 'General Therapy' and 'Specific CBT' skills. In general, trainees arrived at training with more developed general therapy skills. This was not surprising in that a mastery of basic counselling skills was a requirement for entry to the course in the study. Some of the general therapy skills, such as Agenda-setting and Pacing, are, however, less associated with the humanistic models of counselling to which many of the trainees had previously been exposed. Trainees showed particular difficulty with agenda setting and this constituted the most persistently failed item of the CTS-R in this study. Although at the beginning of training trainees showed problems with pacing, they were able to resolve these difficulties more quickly than they were with the problems associated with agenda-setting. Larger numbers were assessed as lacking specific CBT skills, items such as Guided discovery, Formulation and Applying cognitive and behavioural methods, at pre-training, though these skills were rapidly learned towards the end of training. Although, trainees were more able to perform the skills of Eliciting cognitions and Eliciting emotions, they were less successful with Eliciting behaviours. There appeared to be a blind spot to behavioural work even among these trainees in CBT. The skill of setting homework was demonstrated by a surprisingly high number of trainees at pre-training and was not problematic to master later for the other trainees.

The difference between the competency acquisition rates for agenda-setting and setting homework is particularly interesting. Both are concerned with structuring the therapy, the former is a device for opening the structured therapy session and the latter a device for closing it. Amongst the individual CBT principles of the CBPI, agreement with the principle of structuring therapy was the weakest recorded agreement level for any principle. Reservations about structuring were particularly stressed by trainees who began training by preferring the PCT and Psychodynamic models. This low level of agreement was evident in both responses to the CBPI and in

comments made during the semi-structured interviews. Trainees frequently described a struggle with the structuring requirements of CBT. They also referred to strategies used to resolve these struggles. Although agreement with the structuring principle was even lower amongst Psychodynamic trainees than it was for PCT trainees, Psychodynamic trainees mentioned the issue less in the interviews and gave the impression of a more pragmatic adaptation to this requirement. PCT trainees really seemed to struggle with achieving competence in agenda-setting and in the interviews referred to their fears of appearing overly directive with clients by setting an agenda and undertaking other more directive CBT interventions. Non-directiveness has been a prime principle of the PCT approach (Rogers, 1942, 1980). In contrast trainees had few reservations about setting homework, which was widely seen by trainees from all model preferences as enhancing the possibility of change for clients. It might also be that more skill disruption is caused by the agenda setting requirement because it comes right at the start of the session before the therapist has had time to settle in with the client. In effect, it requires that the therapist takes some degree of control of the session right from the very start, without yet having a sense of mandate to do so. In contrast, with regard to setting homework, the trainee therapist has had more opportunity to get the 'lay of the land' and to ascertain the client's likely interpersonal response to being asked to do homework.

A number of important issues are suggested by this comparison of requiring trainees to set agendas and homework. Firstly, it seems possible that various skilled behaviours are influenced by specific task-interfering attitudes and cognitions, rather as the 'cognitive specificity hypothesis' links, for example, 'depressogenic' cognitions with the emotions and behaviours of depression (Beck, 1976). In this case, specific attitudes doubting the desirability of structure in therapy will particularly interfere with skilled behaviours focused on implementing structure. Secondly, the extent of disruption of skilled behaviour may be affected by contextual factors such as the sequence of expected behaviours. In this case, behaviours expected to be demonstrated at the start of the sequence of CBT behaviours, e.g., Agenda setting, may be more easily disrupted than behaviours that are expected to be demonstrated at the end of the sequence – e.g., Homework setting. Thirdly, attitudes that are highly salient for trainees may be particularly hard to suspend whilst trying out a new skill. PCT trainees made frequent reference to 'person-centred values' during the interviews

and these references often showed that these values seemed threatened by having to implement a CBT approach. These comments often showed a sense of threat and described almost frantic attempts to resolve the sense of crisis that came in wake of threat. Such crises may be understood as the discomfort of cognitive dissonance. Atherton (1999) has described how trainees may feel more threatened by new learning that appears to be 'supplantive' – i.e., designed to replace current ideas or behaviours – than 'additive' – designed to operate alongside existing ideas or behaviours. Processes of resolving contradictory ideas may be facilitated by Socratic dialogue, in both general discourse (Nehemas, 1998) and in therapy (Beck et al, 1979). It may also be that experiences of resolution are facilitated by understanding changes in attitudes through the elaboration likelihood process (Petty & Cacioppo, 1986). In contrast to the sense of crisis described by some trainees, one of the psychodynamic interviewees seemed able to take on her supervisor's advice to 'change your language and suspend disbelief' (361/A5) - an altogether more pragmatic approach which in effect accepted that certain trainee requirements might be dealt with by less central cognitive process.

The interview data showed that trainees approached training in CBT with differing degrees of idealism and pragmatism about how far they would absorb CBT principles and practice methods. The majority of trainees held some reservations about CBT and these were likely to raise a degree of cognitive dissonance in the learning process. Some did regard the training as more additive' and some as more supplantive (Atherton, 1999). An additive perspective was that CBT concepts and methods might be integrated with current methods to evolve an eclectic form of practice or that they might be integrated by combination with another model. A supplantive perspective accepted that CBT methods would be implemented in a more complete way that may well eclipse certain previous elements of practice. A trainee who perceived the training requirement in this way could therefore fear that previous competencies could be lost and a number of interviewees made this observation (for example, Interviewee 472 answering question A7).

The imperative to learn CBT in a through way sometimes challenged the additive perspective, precipitating a sense of crisis in some trainees. Sometimes trainees responded by 'trying too hard to be CBT' (see response of 349 in Chart 6a) and became becalmed by anxiety and over-rigid attempts 'to do as the tutors said'.

Trainees who described this dilemma also described finding their way out of it by adopting a more relaxed attitude towards the training. This allowed them to step back from trying too hard and then allowed them to 'play with' the CBT model and find ways to implement their own version of it –at least as a stating point. Such manoeuvres seemed to lead to increased confidence and better skill performance. Trainees often seemed to find these processes of attitude shifts for themselves. Occasionally an attitude shift was aided by comments from tutors and other trainees, rather than by formal training processes.

The interview also allowed trainees to reflect on their experience of implementing CBT after training. Many reported permanent changes to their practice and on-going engagement with the CBT community via the professional association. Others reported partial changes in practice and little engagement with the wider CBT community. One trainee, a committed Christian, referred to herself as 'convert' to CBT. Though few others used this expression, it is perhaps instructive to reflect on the definition of 'conversion' suggested by Blomberg (2006, p.89): 'A radical reorientation of conviction and belief of conduct and, behaviour, of group affiliation and belonging.' Though most trainees did not show changes in all these areas, most did refer to changes in some of them: including the degree to which they practiced CBT, changes in work patterns, and professional and personal engagement with the CBT community. The degree to which they followed these directions often related back to their pre-training preference – the further they had gone in a CBT direction previously, the further they went on now.

The study also collected data on employment factors, particularly on the degree to which employers had encouraged trainees to get training specifically in CBT as a form of 'evidence-based practice.' There was little evidence of such employer influence, especially in the first cohort, 2000-2001. Employer influence was somewhat more evident in the final cohort, 2002-2003, and also in the interviews, when a number of trainees reported professional progress after training through achieving CBT accreditation and/ or new employment that was more CBT-related.

7.5: Implications of the study for further research

This study explored an area – training in psychological therapy - that as yet has not been widely researched. It may be that as the current emphasis on questions about effective psychological therapy is increasingly consensual so more attention can to turn to research into the types of training best suited to support the development of therapists who can implement effective therapy. Such research will need to consider the reality of helping some trainees to change models. Future researchers will be able to build on this study but before making suggestions about lines of such research, it is first necessary to reflect on the validity and reliability of the data of this study and some of methodological issues that have arisen during this research.

The work on establishing the validity and reliability of the CTS-R competence measure has been extensively described and referenced in Chapters 3 and 4.

The concepts of validity and reliability are used somewhat differently in quantitative and qualitative research but have the same underlying meaning (Ritchie & Lewis, 2003). Validity refers to the extent to which the concepts being targeted are being truly represented. There are commonly held to be three types of validity: criterion validity, content validity and construct validity (de Vaus, 2001). Criterion validity examines how responses to the measure in question match with existing measures known to be valid. Content validity examines the extent to which a measure relates to a wide range of meanings in the concept under review. Construct validity refers to the extent to which the measure conforms to theoretical expectations.

The CBTTQ questionnaire and its accompanying inventory, the CBPI, were new measures devised by the author of the study. The content of the CBPI was based on a set of principles for CBT that have been developed by Beck and his associates over nearly forty years (Beck, 1967; Beck, 1976; Beck et al, 1979; Beck & Emery, 1985; Beck, 1991a; Beck, 1995; Beck, 2004). Some limitations of the CBPI have already been acknowledged but nevertheless, the measure did conform to theoretical expectations in discerning clear and significant differences in the way trainees responded to the inventory before and after training. All accounts of CBT stress that it is a fusion of general therapy skills, including interpersonal effectiveness and the capacity to form therapeutic relationships, and more specifically cognitive behavioural technical skills. Both the CBPI and the CTS-R contained items related to

both general therapy and technical skills and the analysis of this study and elsewhere (Blackburn et al, 2001b) showed that respondents gave consistent responses within these different areas. For example, in this study the same respondents often highlighted difficulties in agreeing with the structured aspect of CBT in the CBPI, in the open questions of the CBTTQ, in the interviews and in the assessment of their performance on CBT skill items that involved structuring the therapy.

Ritchie and Lewis (2003) distinguish between ways of establishing the internal and external validity of qualitative data. Internal validity may be clarified by taking steps to check the goodness of fit of categories that emerge from the analysis. In this study, the author's initial use of categories was interrogated via discussion with a group of 'critical friend' colleagues who were given access to the interview transcripts and contributed to discussion about what categories seemed relevant to them. External validation of interview data may be enhanced by triangulation – for example by the use of different types of data to bear on the same phenomena. This study had the benefit of having both questionnaire and interview data that reflected on the views and experiences of trainees in relation to evolving a therapy orientation, developing therapy skill competence and training for therapy. Consistent responses were clearly evident for both the questionnaire and interview data. For example, PCT trainees reported fears about the over-structured nature of CBT in pre-training questionnaires and in interviews conducted one year the end of training.

Reliability of a measure is established by showing that it has internal consistency in the way it measures items. The reliability of the CBPI was established by subjecting the measure to analysis using Cronbach's alpha. The usual minimum reliability level is suggested to be 0.75 (Hinton et al, 2004). All the analyses of different sections of the CBPI data using Cronbach's alpha exceeded this level, as did the supplementary analysis of other reliability tests such as Spearman-Brown. The reliability of the measure would, however, have been further enhanced by using a test-retest procedure before its initial administration so that as this was not carried out, it must be acknowledged as an omission.

Ritchie & Lewis (2003) argue that the reliability of qualitative data is primarily addressed by the researcher being as transparent as possible about the procedures that

have been followed. In this study procedures of data collection have been fully described and the steps of analysis of the interview data have been presented, along with full transcripts of the interviews.

The findings of the study are limited by the fact that the data was gathered within a single course centre. The data may therefore reflect some aspects of that particular course centre. The author was involved as a course tutor in this course centre and this raised some difficulties connected with 'social desirability' - the potential for trainees to report what they thought a tutor might want to hear (de Vaus, 2001) – and by the position of power held by the author in relation to trainees. Efforts were made to reduce these potential limitations by emphasising that trainees should only participate in the study in a voluntary capacity and could withdraw from the study at any time. The degree of confidentiality was maximised by anonymising data collection until the point when trainees had completed all their studies at the training centre. The principle of trainee consent would, however, in retrospect, have been made clearer had the trainees been asked to give written consent to be in the study. It would also have been helpful for the study to pass through a formal ethical approval process, had one existed at the time of the start of the study.

The potential for improving other aspects of the design of the questionnaire became evident as the study progressed: for example, supplying a definition of the model labels for example,'CBT' and 'Person-centred therapy' would have resulted in respondents making more informed choices between them. Attitude questions could have profitably contained more items, including some with reverse scoring. The scoring of some of the measures might have revealed richer data if they had been designed differently: for example, offering a neutral score for the principle statements in the CBPI. Using the full scoring range of the CTS-R might have revealed more aspects of skill performance. The CTS-R assessments in the study were based on a small number of tapes submitted by each trainee and thus probably only showed that trainees were capable of performing competently on those occasions. A fuller and wider knowledge of the trainees' everyday practice would have given a fuller picture of their competence. It should be noted however that tape and practice assessment is very time consuming work and would probably require a large team of assessors able to devote considerable time to the task, also assuming that problems of access to on-

going therapy sessions and permissions needed from clients and agencies could be surmounted. Finally, comparisons of skill performance would have been enhanced by full assessment of all the CTS-R skills items at all stages.

Some of limitations were evident to the researcher during the course of the study itself but to have changed them would have limited the degree to which data already collected could be compared with data collected by amended research methods. One of the limitations of longitudinal and repeated measures design is that, though it is rewarding to track the development of trainees over time, identifying a limitation may well face the researcher with the stark choice of starting again or living with the limitation.

7.6: Suggestions for further research:

The scope of this kind of study could be enhanced by focussing on the widest possible range of instances of trainees demonstrating their levels of competence via submitting audio tapes. A larger scale study would enrich our current knowledge if it was able to gain access to a wider sample of trainee skill performance over longer periods both during and after training. Alternatively a smaller scale study could perhaps pursue this same objective by following a small number of trainees as case studies.

Because PCT trainees were so prominent on this course, the study has been able to show some interesting connections between specific ways of holding PCT attitudes and the performance of specific skills. The study found out less about other specific attitude affects connected to the other therapeutic modalities. Persons et al (1996), for example, made a convincing analysis of psychodynamic reservations about CBT but did not offer any analysis on whether these reservations did have any effects on skill acquisition. Generally, work that focused on specific interaction effects between various attitudes and the acquisition of competence would help trainers to respond more effectively to trainees undergoing these struggles. Although this study has been of CBT training, it is likely that there are parallel effects in other types of training. Trainers would benefit from knowledge of a wide range of training situations, as this study benefited from the findings of Mackay et al (2001) on how counsellors tried to 'change models' into interpersonal dynamic therapy.

Finally, in this study, attitudes towards 'non-directiveness' were shown to play an influential part in the way trainees responded to CBT training. Attitudes towards this principle often seemed rather polarised, as if PCT was entirely 'hands-off' and CBT was entirely 'hands on'. It would be interesting for researchers to get a clearer picture of how directing clients actually worked out in practice and indeed how clients do in fact react to various directive interventions. One respondent in this study remarked that being directive did not mean that one 'went in with hobnail boots on' (See 351 in 6.1.2). Fuller behavioural descriptions of CBT with and without what respondents thought of as 'hob-nail boots' or their equivalents would help trainers to promote sensitive CBT practice. It would also be interesting to know how far clients might discern such behaviours. We might then be more able to discuss whether such 'directive' behaviour was best seen as hidden control or humane concern. Rogers himself (in Kirchenbaum & Henderson, 1990) defines 'directive' and non-directive' therapy as being on a continuum, though they are often discussed as if they were mutually exclusive.

7.7: Generalisation of findings to wider populations

Researchers from such diverse traditions as Cronbach (1975) and Lincoln & Guba (1985) agree that there will always be factors that make a particular setting unique. Lincoln and Guba (1985) argue that any generalisation from one research context to another depends on some level of comparison between the 'sending context' (i.e., the setting of the research study) and the 'receiving context' (the setting to which any generalisation aims to relate). The reader who wishes to estimate the degree to which such transfer is valid will need sufficient detail about the two contexts ('thick description' in Lincoln & Guba's terminology) in order to decide this.

In this study, there were some features of the 'sending context' which may not always be found in other contexts. Firstly, the training course was based in South Wales, a part of the country in which CBT services have been underdeveloped and this fact may partly explain why trainees saw their employers as not giving priority to CBT training. Secondly, the context of the training was in a University college that had a programme of counselling training that culminated in a Masters Degree award. At the time of the study, the Masters arm of the programme contained the CBT training modules and a Masters dissertation. The incentive of the Masters award may have led

some trainees, who otherwise would not have done so, to undertake CBT training. Some trainees in the interviews alluded to the fact that, though they had found CBT training valuable, having a Masters degree meant more to them and their career development. Finally, although the course did include a small number of psychologists, nurses and social workers, the participants had most often emerged from previous counselling training and often described their work as 'counselling', a context that has been particularly influenced by the person-centred, Rogerian tradition. Sheldon (1995) has, however, reported how social worker trainees often seem resistant to cognitive and behavioural methods in ways very similar to how the trainees in this study report themselves to be. Kazantzis et al (2004) reported similar reservations about the directive nature of CBT homework setting amongst clinical psychology trainees in New Zealand. CBT training courses elsewhere may, however, show less occupational and initial model preference diversity. Other courses may be more dominated by trainees from the health services or other psychiatric settings and may bring with them more experience in methods more widely practiced in those settings.

Other features of the sending context, however, may seem more likely to encourage some degree of generalisation. The literature, for example, shows that trainees have come to CBT training with diverse paradigms in other contexts, for example in the context of Americans training for clinical psychologists (Persons et al, 1996; Freiheit & Overholser) and in the contexts of British and American (Morgenstern et al, 2001) training for counsellors. The broad findings of these studies are in line with the main conclusions of this study: that generally attitude differences connected to therapy models can be resolved during training. The resolution of difficulties in 'changing models' is not however always entirely smooth. Resolution seems to be enhanced by certain types of sensitive responses from trainers. Even given sound training practices, however, there does seem to be a minority of trainees who continue to struggle and thus may drop out or be delayed or never achieve practice competence.

7.8: Implications for CBT training policy:

New Labour social policy has had two particular elements that have assisted the promotion of cognitive behaviour therapy in the last decade: the development of evidence based effective public services and service development to counter social

isolation (Giddens, 2007). The initial impetus for a definite plan to develop CBT came from a report written by Lord Layard for the Sainsbury Mental Health Centre (Linklater, 2006). Layard proposed a large increase in funding for improving access to psychological therapy, justified by the savings from benefit provision resulting from people with successfully treated anxiety and depression return to work more quickly. We have already reviewed some of the evidence regarding the efficacy of CBT and Lord Layard, as part of his intense political lobbying, added to this rationale the idea that a scheme to improve access to therapy would also tackle deprivation – 'psychic deprivation' (Hodson & Browne, 2008, p. 4).

Layard's lobbying resulted in Alan Johnson's, Health Secretary, announcing in December 2007 the provision of £173 million for developing therapy, largely CBT, training and provision (CBT Today, December, 2007). Layard explained the emphasis on CBT as justified by the efficacy evidence and by the fact that the greatest shortage lies in the number of available CB therapists. He also clarifies that the required recruitment for CBT training will be wide:

> Some of the trainees will be clinical psychologists but the majority will be drawn from other mental health professions, for example, nurses, social workers and counsellors taking one year training in CBT (CBT Today, December, 2007, p. 4).

Given the reservations of other therapeutic modalities about CBT, these proposals have predictably raised protest and reservations from them. These objections have ranged from root and branch of the model:

> CBT... was originally designed using animal experimentation ... It is well known that cognitive techniques were used to try to make people conform to society's view of normality, for example in the 1950s, and that CBT was widely used in China in the Cultural revolution... These therapies deny the input of the therapist... (Pointon, 2008, p. 21).

To more practical objections – for example, some therapists have asked whether one year trained CBT therapists be regarded as senior to psychodynamic therapists who trained for 5 years (Hodson & Browne, 2008, p. 6).

It is likely therefore that the issue of trainees changing models as they come into CBT training will arise as the new training attitudes interact with previously held attitudes.

It is also clear that the implementation process, just beginning as I write (March, 2008) will be rapid and, as with many recent initiatives, the detail is not clear even as the process begins. A major fact of the likely relevant detail arises in the nature of the 'stepped care' concept built into the Layard proposals. Stepped care involves different levels of psychological treatment from the 'high volume, low intensity' interventions of Step 1 to the 'low volume, high intensity' interventions' of Step 5 (White, 2008). It is assumed that different professions will gravitate to different steps, clinical psychologists towards the higher steps and others towards the lower ones (CBT Today, December, 2007, p.2). So whilst Layard is right that many professions are likely to be involved in the Improving Access to Psychological Therapy (IAPT) project, how they will be involved and what training and opportunities are open to them is not yet clear. Some have referred to people working on steps 1 to 4 as 'technicians' and step 5 as 'therapists' (CBT Today, December, 2007, p. 2) – an approach likely to exacerbate the paradigmatic and attitudinal training conflicts discussed earlier.

This study does, however, suggest ways in which such training difficulties can be tackled – ways that bear comparison to CBT itself. It shows that certain attitudes held in particular ways do interfere with the acquisition of CBT competence, sometimes in highly specific ways. These attitudes may, as in this study, be connected to theoretical orientation but similar attitude differences that arise between the different occupational groups struggling to get on the 'Layard score board'. The study also suggests that these difficulties can be overcome by a training process that provides a supportive environment in which attitudinal differences can be surfaced, explored and, mostly, resolved. Such a supportive environment may, however, need to take care that all professional groups are respected and that professional politics arising in other contexts are minimised in this one.

7.9: Implications for CBT training methods:

In view of the large scale nature of the Layard training plan, it seems likely that more people from diverse ranges of previous experience and points of view will present themselves for CBT training in the coming years. It is therefore important to understand how these previous experiences and previously held attitudes may influence response to CBT training, especially in the way that they develop

competence in their practice of the model. Speedy (1998) has noted the clash between the ethos of 'non-judgemental' counselling courses and university assessment processes. To this can be added the clash between the ideals of self-directed learning and the drive for vocational and skill based education. As we have examined the educational issues we have however noted that concepts often act as polarities and that trainees may want things from both polarities: for example, externally validated qualifications and a learning experience that gives them experience of at least some self-directed learning. Many authors have argued that something like Socratic dialogue and negotiation can lead to creative compromise and resolution between them (Speedy, 1998).This study has also shown that resolving these differences can involve considerable dissonance and stress for trainees.

This study suggests that:

- Training processes are mostly capable of helping trainees to reformulate their existing attitudes in such a way they are able to attain competence.

- Considering processes to facilitate attitude change by using Socratic discussion based on models such as elaboration likelihood (Petty & Cacioppo, 1986) is helpful for trainers seeking to find the balance between facilitating trainees' development and persuading them of the benefits of new learning. The model is also helpful to trainees: they can use it identify any reservations about learning the therapy and what ways of resolving such reservations may be open to them.

- Some of the dissonance felt by trainees may be hard for them to declare without seeming to be out of kilter with the training. Some of the stress may therefore be kept hidden from trainers. Training processes that could make it safe for trainees to surface their reservations would be helpful. It may also be helpful to have an agreed way for trainees to decide that the training is not for them so that they can effectively give themselves an 'honourable discharge' from

courses. The lack of such an option may mean trainees can only do this in rather messy ways by appearing to 'fail'. As trainers themselves become more aware of how such impasses could be resolved, they will be able to be more helpful to trainees at this point.

- During the processes of Socratic dialogue and elaboration likelihood designed to facilitate attitude change, it will be helpful if trainee and trainers are more aware of the way attitudes may impact on the acquisition of competence. This study suggests that there may be **specific attitude effects.** For example, reservations about the principle that therapy is structured may lead to trainees finding it difficult to structure the session. More specifically still, because the structuring activity of setting an agenda has to be undertaken quite near to the start of the session to be meaningful, any procrastination about carrying out the activity may be fatal for successful assessment of the skill. The specifications for demonstrating the skill of agenda setting include the fact that it should be done in a relevant way – delay in setting an agenda may lead to its immediate irrelevance in that the delay may leave insufficient time for topics to be covered. It was interesting that agenda setting was the most failed item of assessment in this study. Other structuring activities such as pacing the session were not so time-bound and trainees mastered them more quickly. Homework setting comes towards the end of a session and gives the therapist more time to settle into a good interpersonal style with the client.

- The process of reviewing and modifying attitudes may be helpfully supplemented by a process of reflection and practice (Bennett-Levy & Thwaites, 2006) during which a trainee can be encouraged to 'play with' the model, wear it more lightly and to implement aspects of it at her own pace as it becomes more comfortable to her. These methods can be used in an educational practice which utilises the principles of reflective practice, self-directed and experiential learning as well as focusing on structured professional learning.

7.10: Conclusions

This study has been able to identify some commonly assumed facets of training – attitudes and practice behaviours of trainees develop during and after training – in precise and concrete ways. It has also been able to show that the development of attitudes is linked to the development of skilled practice behaviours. The effect of attitudes on practice behaviours was most evident at the pre-training stage, lessened during the early stages of training and was largely neutralised by the end of training. The study has suggested that it is helpful to target specific attitudes and the way they might link to specific practice skill behaviours. Precise understanding of the context of the use of each skill can clarify important aspects of difficulty that trainees may experience in implementing them. Interviews conducted after the end of training suggest that attitude change during training had been largely maintained at one year follow-up. It was not possible to measure whether skill acquisition had been retained during the post-training period, though interviewees frequently reported the intention to maintain and increase commitment and engagement with the skilled delivery of CBT. Trainees also reported the kinds of personal and occupational change that were likely to sustain development of CBT practice – for example, moving into more specialised posts and engaging with professional associations and activities linked with CBT practice.

The study may also prove helpful to trainers and trainees by identifying the possibility that specific attitudes towards therapy may be linked with specific aspects of skill performance. It has also identified elements of the kind of processes, based on an understanding of how Socratic exchange and the influencing process may facilitate attitude change. Such attitude changes may facilitate skill development. The linkage of cognitive processes and behavioural change has a satisfying congruence with the CBT model itself.

With CBT training set to expand in the UK following the Layard plan, understanding such training processes should help to ensure that training is carried out in effective ways.

REFERENCES

Aldridge, S & Rigby, S (2001) *Counselling skills in Context* London: Hodder & Stoughton.

Alford, B.A., & Beck, A.T. (1997) *The Integrative Power of Cognitive Therapy,* New York: Guilford.

American Psychiatric Association (APA, 2000) *Diagnostic and Statistical Manual, 4th Edition, Text Revision* Washington: APA.

Andrews, G. (1999) Randomised controlled trials in psychiatry: important but poorly accepted. *British Medical Journal,* 319: 562-564.

Aronson, E., & Pratkanis, A. R. (2001) *Age of propaganda: The everyday use and abuse of persuasion.* New York: Henry Holt.

Arthur, S., & Nazroo, J. (2003) Developing fieldwork strategies and materials. In J. Ritchie & J. Lewis (Eds) *Qualitative research practice: a guide for social science students and researchers.* London: Sage, 109-137.

Ashworth, P., Williams, C., & Blackburn, I-M (1999) What becomes of cognitive therapy trainees? A survey of trainees' opinions and current clinical practice after postgraduate cognitive therapy training *Behavioural and Cognitive Psychotherapy,* 12:267-277.

Atherton, J. (1999) Resistance to Learning: a discussion based on participants in in-service professional training programmes *Journal of Vocational and Educational Training,* 51.1: 77- 90.

Atherton, J. (2003) *Learning and teaching: cognitive dissonance* (On-line) UK: Available. http://www.dmu.ac.uk/~jamesa/learning/dissonance.htm Accessed, 10 May 2004.

Aurelius Antoninus, Marcus. (1989) *The Meditations of Marcus Aurelius Antoninus.* Translated by the late A.S.L. Farquharson, with Introduction by R.B.Rutherford. Oxford: Oxford University Press.

Ayllon. T. & Azrin, N. (1968) *The Token Economy.* New York: Wiley.

Bandura, A. (1969) *Principles of Behavior Modification* New York: Holt, Rinehart & Winston.

Barker, P. & Buchanan-Barker, P. (2004) *The Tidal Model: a guide for mental health professionals.* London: Brunner-Routledge.

Barlow, D.H. (1988) *Psychological Treatment of Panic,* New York: Guilford.

Bartlett, F.C (1932) *Remembering: a study in experimental and social psychology* Cambridge: Cambridge University Press.

Basoglu, M., Marks, I.M., Kilic, C., Swinson, R.P., Noshirvani, H., Kuch, K. O'Sullivan, G. (1994) Relationship of panic, anticipatory anxiety, agoraphobia with global improvement in panic disorder with agoraphobia treated with alprazolam and exposure. *British Journal of Psychiatry*, 164: 647-652.

Baxter Magolda, M (1996) Epistemological development in graduate and professional education. *Review of Higher Education*, 18.1:25-44.

Bazeley, P., & Richards, L. (2000) *The Nvivo Qualitative Project Book*. London: Sage.

Beck, A.T. (1967) *Depression: Clinical, Experimental and Theoretical Aspects*. New York: Harper & Row.

Beck, A.T (1976) *Cognitive Therapy and the Emotional Disorders*. Harmondsworth: Penguin

Beck, A.T. (1988) *Love is Never Enough*. Harmondsworth: Penguin.

Beck, A.T. (1991a) The Cognitive Therapy of Depression: a 30 Year Perspective, *The International Journal of Cognitive Therapy*, 1.1:1-12.

Beck, A.T. (1991b). Cognitive therapy as the integrative therapy. *Journal of Psychotherapy Integration*. 1: 191-198.

Beck, A.T. (1996) Beyond belief: a theory of modes, personality and psychopathology. In Salkovskis, P. (Ed.) *Frontiers of cognitive therapy*. New York: Guilford.

Beck, A.T., Brown, G., Steer, R.A., Eidelson, J.I., & Riskind, J.H. (1987) Differentiating anxiety and depression: a test of the cognitive specificity hypothesis. *Journal of Abnormal Psychology*, 96.3:179-183.

Beck, A.T. & Emery, G with Greenberg, R. (1985) *Anxiety Disorders and Phobias: A cognitive perspective*. New York: Basic Books.

Beck, A.T., Freeman, A., & Davies, D. (Eds., 2003) *Cognitive Therapy of Personality Disorders* (revised edition) New York: Guilford.

Beck, A.T. & Hollon, S. (1993) Controversies in cognitive therapy: Dialogue between Aaron Beck and Steve Hollon, 1992 World Congress of Cognitive Therapy, Toronto. *Journal of Cognitive Psychotherapy*, 7.2: 79-93.

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979) *Cognitive Therapy of Depression*. New York: Guilford.

Beck, A.T., Sokol, L., Clarke, D.A., Berchick, B & Wright, F. (1992) Focused cognitive therapy of panic disorder: a cross-over design and one year follow-up. *American Journal of Psychiatry*, 147: 778-783.

Beck, A.T & Young, J.S (1985) Depression, in D.H. Barlow (ed) *Clinical Handbook of Psychological Disorders.* New York: Guilford, 206-244.

Beck, J. (1995) *Cognitive Therapy: Basics and Beyond.* New York: Guilford.

Beckham, E., & Watkins, J. (1989) Process and outcome in cognitive therapy In A. Freeman, K. Simon, L. Beutler, & H. Arkowitz (Eds.) *Comprehensive handbook of cognitive therapy,* New York: Plenum, 61-81.

Bennett-Levy, J. (2002) *Cognitive Therapy in Three Dimensions: Mapping the Impact of Self-practice and self-reflection (SP/SR) in the Training of Cognitive Therapists.* Unpublished PhD Thesis. Southern Cross University, New South Wales, Australia.

Bennett-Levy, J (2006) Therapist skills: a cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy,* 34.1: 57-78.

Bennett-Levy, J., Butler, G., Fennell, M., Hackmann. A., Mueller, M., & Westbrook, D. (2004). *Oxford Guide to Behavioural Experiments in Cognitive Therapy.* Oxford: Oxford University Press.

Bennett-Levy, J., & Thwaites, R. (2006) Self and self-reflection in the therapeutic relationship: a conceptual map and practical strategies for the training, supervision and self-supervision of interpersonal skills. In P. Gilbert & R. Leahy (Eds.), *The Therapeutic Relationship in the Cognitive Behavioural Psychotherapies.* London: Routledge, 255-281.

Bennett-Levy, J., & Beedie, A. (2007) The ups and downs of cognitive therapy training: what happens to trainees' perception of their competence during a cognitive therapy training course? *Behavioural and Cognitive Psychotherapy,* 35: 61-75.

Beutler, L.E., Machado, P.P.P., & Neufeldt, S.A. (1994) Therapist Variables. In, A.E.Bergin & S.L.Garfield. (Eds) *Handbook of Psychotherapy and Behavior Change.* 4th Ed., 229-269.

Blackburn, I-M., Davidson, K. (1994) *Cognitive Therapy for Anxiety and Depression.* Oxford: Blackwell.

Blackburn, I-M., James, I.A., Milne, D.L., Baker, C., Standart, S., Garland, A., & Reichelt, F.K. (2001) The revised cognitive therapy scale: psychometric properties. *Behavioural and Cognitive Psychotherapy,* 29: 431-446.

Blocksma & Porter (1947) Short-term training program in client centred counselling, *Journal of Consulting Psychology,* 11: 55-60.

Blomberg, C (2006) *From Pentecost to Patmos: Acts and Revelation – an introduction and survey,* Nottingham; Apollos (Intervarsity).

Bolger, A.W. (1985) Training and research in counselling. *British Journal of Guidance and Counselling,* 13: 112-124.

Bolter, K., Levenson, H., Alvarez, W. (1990) Differences in values between short term and long term therapists. *Professional Psychology: Research and Practice*, 4. 285-290.

Botella, C. & Garcia-Palacios, A. (1999) The possibility of reducing therapist contact and total length of therapy time in the treatment of panic disorder. *Behavioural and Cognitive Psychotherapy*, 27.3: 231-247.

Bowers, P., Byford, S., Sibbald, B., Ward, E., King, M., Lloyd, M., & Gabbard, M. (2000) Randomised controlled trial of non-directive counselling, cognitive behavioural therapy and usual GP care for patients with depression: cost effectiveness. *British Medical Journal*, 321: 1389-1392.

Brewin, C. (1988) *Cognitive Foundations of Clinical Psychology London*: Lawrence Erlbaum.

Brewin, C (1996) Theoretical foundations of cognitive behavioural therapy for anxiety and depression. *Annual Review of Psychology*, 41: 39-57.

British Association for Behavioural and Cognitive Psychotherapies (BABCP, 1999). *Minimum standards for training in cognitive and behavioural therapies*, Accrington: BABCP.

British Association for Counselling (BAC) (1994), *Membership Survey* (1993), Mountain & Associates, Marketing Services Ltd, Keele. Rugby: BAC.

British Association for Counselling (1996) *Ethical guidelines for monitoring, evaluation and research in counselling*, Rugby: BAC.

British Association for Counselling & Psychotherapy (1998), *Counselling in a Health Centre*. Rubgy: BACP.

British Association for Counselling and Psychotherapy (BACP, 2002) *Accreditation of Training Courses*. Rugby: BACP.

Bruch, M & Bond, F.W. (1998) *BeyondDiagnosis: case formulation in CBT* Chichester: Wiley.

Bryman, A. (2004) *Social Research Methods 2nd Ed.*, Oxford: Oxford University Press.

Buber, M. (1970) *I and Thou. 3rd Ed.* Edinburgh: T & T. Clark.

Burgess, H., & Taylor, I (2005) *Effective Learning and Teaching in Social Policy and Social Work*, New York: Routledge.

Burns, D.D & Nolen-Hoeksema, S. (1991) Coping styles, homework assignments and the effectiveness of cognitive behaviour therapy *Journal of Consulting and Clinical Psychology*, 39: 305-311.

Burns, D.D& Spangler, D.L. (2000) Does psychotherapy homework lead to improvements in depression in cognitive-behavioural therapy or does improvement lead to increased homework compliance? *Journal of Consulting and Clinical Psychology,* 68.1: 46-56.

Busch, F.N. & Mildrod, B. (2004) The nature and treatment of panic. In Panskepp, J (Ed., 2004) *The Textbook of Biological Psychiatry.* New York: Wiley, 345-366.

Cahill, J (1996) Patient participation: a conceptual analysis, *Journal of Advanced Nursing,* 24.3: 561-571.

Carkhuff, R.R (1969a) *Helping and Human Relations: a primer for lay and professional helpers,* Vol: I, London: Holt, Rinehart & Winston.

Carkhuff, R.R. (1969b) *Helping and Human Relations: a primer for lay and professional helpers,* Vol: II. London: Holt, Rinehart & Winston.

Carkhuff, R.R (1987) *The Art of Helping VI.* Amhurst, Mass.: Human Resource Development.

Cassidy, K-L (2004) The adult leaner rediscovered: Psychiatric residents push for cognitive behaviour therapy training and a learner-driven mode of educational change, *Academic Psychiatry,* 28: 215-220.

Castelnuovo, G., Faccio, E., Molinari, E., Nardone, G., & Salvini, A. (2004), A critical review of empirically supported treatments (ESTs) and Common Factors perspective in Psychotherapy *Brief Strategic and Systemic Therapy European Review,* 1: 208-224.

Cautela, J.R. (1967) Covert desensitization *Psychological Reports.* 20: 459-468.

Chambless, D.L. (2002) Beware the Dodo Bird: the dangers of over-generalisation. *Clinical psychology: Science & Practice,* 9.1: 13-16.

Chambless, D.L., & Ollendick, T.H. (2001) Empirically supported psychological interventions: controversies and evidence. *Annual Review of Psychology,* 52: 685-716.

Charmaz, K. (1995) Grounded theory. In Smith, J.A., Harre, R., Van Langenhove, L. (Eds, 1995) *Rethinking Methods in Psychology.* London: Sage.

Chilvers, C., Dewey, M., Fielding, K., Gretton, V., Miller, P., Palmer, B., Weller, D., Churchill, R., Williams, I., Bedi, N., Duggan, C., Lee, A., & Harrison, G. (2001) Antidepressant drugs and generic counselling for the treatment of major depression in primary care: randomised trial with patient preference arm. *British Medical Journal,* 322: 722.

Clark, D.A. & Steer, R.A. (1996) The empirical status of the cognitive model of anxiety and depression, in Salkovskis, P (Ed) (1996) *The Frontiers of Cognitive Therapy.* New York: Guilford, 75-96.

Clark, D.A., Beck, A.T. & Beck, J.S (1994). Symptom differences in major depression, dysthymia, panic disorder and generalised anxiety disorder. *American Journal of Psychiatry*, 151.2: 205-209.

Clark, D.M. (1986), A cognitive approach to panic. *Behavior Research and Therapy*, 24: 461-470.

Clark, D.M. (1996), 'Panic disorder: from theory to therapy.' Chapter in Salkovskis, P (Ed) *Frontiers of Cognitive Therapy*. New York: Guilford, 318-344.

Clark, D.M., & Fairburn, C. (Eds., 1997) *The Science and Practice of Cognitive Behaviour Therapy*. New York: Guilford.

Clark, D.M., Salkovskis, P.M., Gelder, M., Koehler, C., Martin, M., Anastiades, P., Hackman, A., Middleton, H., & Jeavons, A. (1988) Tests of a cognitive theory of panic in I. Hand & H.U. Wittchen (Eds), *Panic and phobias 2*. Berlin: Springer Verlag.

Clark, D.M., Salkovskis, P.M., Hackman, A., Middleton, H., Anastasiades, P & Gelder, M. (1994) A comparison of cognitive therapy, applied relaxation and imipramine in the treatment of panic disorder. *British Journal of Psychiatry*, 114, 759-763.

Clarkson, P. (1994) *The Achilles Syndrome*. Brisbane: Element.

Clarkson, P., & Mackewn, J. (1993) *Fritz Perls: Key figures in counselling and psychotherapy*. London: Sage.

Corey, G. (2001) *The theory and practice of counselling and psychotherapy*. 6th Ed. Stamford: Brooks Cole.

Crews, F.C. (Ed., 1998) *Unauthorized Freud: Doubters confront a legend*. New York: Viking.

Cronbach, L (1975) Beyond the two disciplines of scientific psychology, *American Psychologist*, 30: 116-127.

Cummings, N.A. (1977), Prolonged (ideal) versus short-term (realistic) psychotherapy. *Professional Psychology*, 8: 491-501.

Cummings, N.A., Budman, S.H., & Thomas, J.L. (1998) Efficient psychotherapy as a viable response to scarce resources and rationing of treatment. *Professional Psychology: research & Practice*, 29: 460-469.

Cummins, N.A., & Sayama, M. (1995) *Focused Psychotherapy: A casebook of brief, intermittent psychotherapy throughout the life cycle*. New York: Brunner/Mazel.

Cummings, N.A., & Cummings, J.L. (2000) *The Essence of Psychotherapy: Reinventing the art in the new era of data*. San Diego: Academic Press.

Dalton, P (2006) *Swing voting: understanding late deciders in late modernity,* Cresskill, NJ: Hampton Press.

Davies, H., & Rushton, R (1991) Counselling and supporting parents of children with developmental delay. *Journal of Mental Deficiency Research,* 35: 207-216.

Department of Health (1999) *Mental Health: National Service Framework.* London: HMSO.

Della Selva, C. (2004) *Intensive Short-term Dynamic Psychotherapy: Theory & Techniques.* London: Karnac.

Denning, P., Little, J., & Glickman, A (2004) *Over the influence: the harm reduction guide for managing drugs and alcohol.* New York: Guilford.

Denzin, N.K. (1994) Postmodernism and deconstruction. In D.R. Dickens & A. Fontana (Eds) *Postmodernism and Social Enquiry,* London: UCL Press.

de Vaus (2001) *Research Design in Social Research.* London: Sage.

Dobson, K.S., & Shaw, B.F. (1993) The training of cognitive therapists: what have we learnt from treatment manuals? *Psychological Theory, Research, Practice & Training,* 70.4: 573-577.

Dreyfus, H.L., & Dreyfus, S.E. (1986) *Mind over Machine: the power of human intuition and expertise in the era of the computer.* New York: Free Press.

Dryden, W. (1985) Challenging but not overwhelming: A compromise in negotiating homework assignments, *British Journal of Cognitive Psychotherapy*; 3.1: 77-80.

Dryden, W (Ed., 1992) *Integrative and Eclectic therapy: a handbook.* Buckingham: Open University Press.

Dryden, W (Ed) (1996) *Research in Counselling and Psychotherapy.* London: Sage.

Dryden, W. (1998) *Are you sitting uncomfortably?* Ross-on-Wye: PCCS Books.

Dryden, W. (2004) *Rational Emotive Behavioural Counselling in Action,* 3rd ed. London: Sage.

Dryden, W., & Mytton, J. (1999) *Four Approaches to Counselling and Psychotherapy,* New York: Routledge.

Durham, R.C., Chambers, T.A., Power, K.G., Sharp, D.M., Macdonald, R.R., Major, K.A., & Ginsley, A.I (2005) *Long term outcome of cognitive behaviour therapy treatment in central Scotland,* HMSO: Health Technology Assessment.

Durkheim, E (1952) *Suicide: a study in sociology*; translated [from the French] by John A. Spaulding and George Simpson. London: Routledge & Kegan Paul,

D'Zurilla, T. J., & Nezu, A. M. (1999). *Problem-solving Therapy: A social competence approach to clinical intervention* (2nd Ed.). New York: Springer.

Eells, T.D. (Ed.1997) *Handbook of Psychotherapy Case Formulation*. London: Guilford.

Egan, G (2002, 7th Ed.) *The Skilled Helper: a problem management and opportunity development approach to helping*. Pacific Grove, Ca. Brooks Cole.

Ehlers, A., Magraf, J., Roth, W.T., Taylor, C.B. & Birbaum, N. (1988) Anxiety produced by false heart rate feedback in patients with panic disorder. *Behaviour Research and Therapy*, 26, 1-11.

Elkin, I., Shea, M.T., Watkins, J.T., Imber, S.D., Sotsky, S.M., Collins, J.F., Glass, D.R., Pilkonis, P.A., Leber, W.R., Docherty, J.P., Fiester, S.J., & Parloff, M.B. (1989). NIMH Treatment of Depression Collaborative Research Program: I: General effectiveness of treatments. *Archives of General Psychiatry*, 46: 971-982.

Ellis, A. (1962) *Reason and emotion in psychotherapy* Secausus, NJ: Citadel Press.

Ellis, A & Dryden, W (1991) *Against dogma*, Milton Keynes: Open University.

Engle, D., Beutler, L.E. & Daldrup, R. J. (1991) Focused expressive psychotherapy: Treating blocked emotions. In Safran, J.D, Greenberg, L.S (Eds., 1991) *Emotion, Psychotherapy, and Change*. New York: Guilford, 169-196.

Epstein, S. (1998) *Constructive Thinking: the key to emotional intelligence*. Westport, CT: Greenwood.

Eysenck, M (1997) *Anxiety and Emotion: A Unified Theory*. Hove: Psychology Press.

Eysenck, H.J. (1960) *Behaviour Therapy and Neurosis: readings in modern treatment derived from learning theory*. Oxford: Pergamon.

Feltham, C (Ed., 1999) *Understanding the counselling relationship*. London: Sage.

Fennell, M.J.V. (1989), Depression in Hawton, K, Salkovskis, P.M., Kirk, J & Clark, D.M. (1989) *Cognitive-behaviour Therapy for Psychiatric Problems*. Oxford: Oxford University Press, 169-234.

Festinger, L. (1957) *A Theory of Cognitive Dissonance*, Evanston: Row Peterson.

Field, A (2000) *Discovering Statistics using SPSS for Windows*, London: Sage.

Flick, U. (1998) *An Introduction to Qualitative Research*. London: Sage.

Foa, E.B., & Kozak, M.J. (1986) Emotional processing of fear: exposure to corrective information. *Psychological Bulletin*, 99.1: 20-35.

Fontana, A., & Fey, J.H. (2000) The interview: from structured questions to negotiated text. In N.K. Denzin & Y.S. Lincoln (Eds) *Handbook of Qualitative Research,* 2nd edition. Thousand Oaks, CA: Sage.

Freiheit, S.R. & Overholser, J.C. (1997) Training issues in cognitive behavioural psychotherapy. *Journal of Behavioural Therapy & Experimental Psychiatry,* 28.2: 79-86.

Frude, N. (2005) Prescription for a good read. *Counselling and Psychotherapy Journal,* February 2005: 16.1: 28-31.

Furukawa, T.A., Watanabe, N., & Churchill, R (2007) *Combined psychotherapy and medication for panic disorder with and without agoraphobia,* Cochrane Database of Systematic Reviews, 2007, Issue4.

Gabbard, G.O (2005) How not to teach psychotherapy. *Academic Psychiatry,* 29.4: 332-338.

Gerth, H.H., & Wright-Mills, C. (1991) *From Max Weber: essays in sociology.* 2nd Edition. London: Routledge.

Giddens, A (2007) *Over to you, Mr Brown: how Labour can win again,* Cambridge: Polity Press.

Goldfried, M.R (Ed., 2000) *How Therapists Change: personal and professional reflections,* Washington: American Psychological Association.

Gotlib, I.H. & Hammen, C.L. (1992) *Psychological Aspects of Depression,* Chichester: Wiley.

Grant, A., Mills, J., Mulhern, R., & Short, N. (2004) *Cognitive Behaviour Therapy in Mental Health Care.* London: Sage.

Greenberg, L.S. (2002) *Emotion-focused Therapy: coaching clients to work through their feelings.* Washington: APA.

Greenberger, D., & Padesky, C.A. (1995) *Mind over Mood.* New York: Guilford.

Grolnick, S.A. (1991) *The Work and Play of Winnicott*, Northvale, NJ: Jason Aronson.

Halligan, F.R (1995) The challenge: Short-term dynamic psychotherapy for college counseling centers. *Psychotherapy: Theory, Research, Practice, Training*, 32.1: 113-121 Special Issue: Adolescent treatment: New frontiers and new dimensions.

Hamilton, M (1960) A rating scale for depression. *Journal of Neurology, Neurosurgery & Psychiatry,* 23: 56-62.

Hammersley, M. & Atkinson, (. (1995) *Ethnography: principles in practice,* 3rd Edition. London: Routledge.

Hansen, A.M., Hoogduin, C.A., Schaap, C. & de Haan, E. (1992) Do dropouts differ from successfully treated obsessive-compulsives? *Behaviour Research and Therapy*, 30.5: 547-550.

Hawton, K., Salkovskis, P.M., Kirk, J., & Clark, D.M. (Eds, 1989) *Cognitive Behavioural Therapy for Psychiatric Problems*. Oxford: Blackwell.

Hay, C.E & Kinnier, R.T. (1998) Homework in counseling. *Journal of Mental Health Counseling*, 20.2: 122-132

Hayes. S.C., V. M. Follette, R. M. Dawes, & K. E. Grady (Eds., 1995) *Scientific Standards of Psychological Practice: Issues and recommendations*. Reno, NV: Context Press.

Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (2004) *Acceptance and Commitment Therapy: An Experimental Approach to Behaviour Change*. New York: Guilford.

Heesacker, M. & Meija-Millan, C. (1996) A Research Programme on Attitude Change Processes and their Applications in Counselling, chapter in Dryden, W. (Ed) *Research in Counselling and Psychotherapy*. London: Sage, 49-77.

Helms, T.E., Henze, K.T., Sass, T.L., & Mifsud, V.A (2006) Treating Cronbach alpha coefficients as data in counselling research, *The Counselling Psychologist*, 34.5: 630-660.

Henrion, R (2001) Meaning in life evaluation scale – homework assignments in logotherapy. In H.G. Rosenthal (Ed., 2001) *Favourite counselling and therapy homework assignments: Leading therapists share their most creative strategies*. Philadelphia, PA, US: Brunner-Routledge (2001).

Henry, W.P., Schacht, T.E., Strupp, H.H., Butler, S.F., & Binder, J.L. (1993a). Effects of time-limited psychotherapy: changes in therapist behavior. *Journal of Consulting and Clinical Psychology*, 61: 434-440.

Henry, W.P., Schacht, T.E., Strupp, H.H., Butler, S.F., & Binder, J.L. (1993b). Effects of training in time limited dynamic psychotherapy: Mediators of therapists' responses to training. *Journal of Clinical and Consulting Psychology*, 61: 441-447.

Herbert, J.D. (2003) The science and practice of empirically supported treatments. *Behavior Modification*, 27 (3): 412-430.

Hersen, M. (Ed., 1995) *Clinical Behavior Therapy: Adults and children*. New York: Wiley.

Hinton, P.R., Brownlow, C., McMurray, I., & Cozens, B (2004) *SPSS explained*, London: Routledge.

Hodson, P & Browne, S (2008) Bringing up IAPT, *Therapy Today*, 3: 4-7.

Holland, S.J., & Leahy, R.L. (2000) *Treatment plans and interventions for depression and anxiety.* New York: Guilford.

Hollon, S.D., De Rubeis, R.J. & Evans, M.D (1996) Cognitive therapy in the treatment and prevention of depression In P.Salkovskis (Ed., 1996) *Frontiers of Cognitive Therapy.* New York: Guilford, 293-317.

Holmes, J. (2000) NHS Psychotherapy: past, present and future. *British Journal of Psychotherapy,* 16.2: 54-175.

Horowitz, M (2005) *Understanding Psychotherapy Change: a practical guide to configurational analysis,* Washington: APA.

Howitt, D., & Cramer, D (2000) *First Steps in Research and Statistics,* London: Routledge.

Hoyt, M.F. (2000) *Some stories are better than others: doing what works in brief therapy and managed care.* Philadelphia, PA.: Brunner/Mazel.

Hudson, B.L. & Macdonald, G.M. (1986) *Behavioural Social Work: an introduction.* Basingstoke: Macmillan.

Huey, D (2001) The potential utility of problem based learning in the education of clinical psychologists and others, *Education for Health,* 14.1: 11-19.

Hunsley, J., & Di Giulio, G (2002) Dodo Bird, Phoenix or Urban Legend? the question of psychotherapy equivalence, *The Scientific Review of Mental Health Practice,* 1.1: 1-19.

Inskipp, F (1996) *Skills Training for Counsellors* London: Sage.

Ivey, A.E *(1987) Intentional Interviewing and counselling: facilitating client development,* 2nd Edition, Pacific Grove, CA: Brooks/Cole.

Ivey, A.E., Ivey, M.B. & Simek-Morgan, L. (1997) *Counselling and Psychotherapy: A Multicultural perspective.* 4th Edition. London, Boston: Allyn & Bacon.

Ivey, A.E., & Authier, J. (1977) *Microskills: innovations in interviewing, counselling, psychotherapy & psycho-education.* Springfield, Ill.: Thomas.

Jacobs, M (1998, 2nd Ed) *The Presenting Past* Buckingham: Open University Press.

Jacobs, M (2004) *Psychodynamic Counselling in Action,* 3rd Ed. London: Sage.

Jacobson, N.S., & Hollon, S.D. (1996a) Cognitive behaviour therapy vs. pharmacotherapy: Now the jury's returned its verdict, it's time to present the rest of the evidence. *Journal of Consulting and Clinical Psychology,* 64: 74-80.

Jacobson, N.S., & Hollon, S.D. (1996b) Prospects for future comparisons between drugs and psychotherapy: Lessons from the CBT vs. Pharmacology exchange. *Journal of Consulting and Clinical Psychology*, 64: 104-108.

James, I.A., Blackburn, *I-M.* & Reichelt, F.K. *(2000) Manual for the revised cognitive therapy scale (CTS-R),* Unpublished manuscript.

Johns, H (1996) *Personal Development in Counselling Training,* London: Cassell.

Johns, H (Ed., 1998) *Balancing Acts,* London: Routledge.

Johnstone, L. & Dallos, R. (2005) *Formulation in Psychology and Psychotherapy.* London: Routledge.

Jongsma, A.E., Peterson, L.M., McInnis, W.P. (2000a) *The Adolescent Psychotherapy Treatment Planner* (2nd ed.). New York: John Wiley and Sons.

Jongsma, A.E., Peterson, L.M., McInnis, W.P. (2000b) *The Child Psychotherapy Treatment Planner* (2nd ed.). New York: John Wiley and Sons.

Kadden, R., Carroll, K.M., Donovan, D., Corey, N., Monti, P., Abranms. D., Litt, M., and Hester, (1992) *Cognitive behavioural coping skills therapy manual: a clinical research guide for therapists treating individuals with alcohol dependence.* NIAAA Project Match Monograph Vol. 3, DHHS Publication number ADM 92 1895, Washington, D.C: US Government Printing Office.

Kazantzis, N (2000) Power to detect homework effects in psychotherapy outcome research. *Journal of Consulting and Clinical-Psychology*, 2000; 68.1: 166-170

Kazantzis, N & Deane, F.P. (1999) Psychologists' use of homework assignments in clinical practice. *Professional-Psychology: Research and Practice*, 30.6: 581-585

Kazantzis, N., & Ronan, K.R (2006) Can between session (homework) activities be considered a common factor in psychotherapy? *Journal of Psychotherapy Integration,* 16.2: 115-127.

Kazantzis, N., & L'Abate, L (2007) *Handbook of Homework Assignment in Psychotherapy,* New York: Springer.

Kazantzis, N., Deane, F.P. & Ronan. K.R. (2000) Homework assignments in cognitive and behavioural therapy: a meta-analysis. *Clinical psychology: Science and Practice,* 7: 189-192.

Kazantzis, N., Lampropoulos, G.K., & Deane, F.P. (2005a) A national survey of practicing psychologists' use and attitudes towards homework in psychotherapy. *Journal of Consulting and Clinical Psychology,* 73.4: 742-748.

Kazantzis, N., Deane, F.P., Ronan, K.R., & L'Abate, L (Eds., 2005b) *Using Homework Assignments in Cognitive Behaviour Therapy,* New York: Routledge.

Keijsers, G.P., Schaap, C.P. & Hoogduin, C.A. (2000) The impact of interpersonal patient and therapist behaviour on outcome in cognitive behaviour therapy: a review of empirical studies. *Behaviour Modification*, 24.2: 264-297.

Kelly, G.A (1969) Humanistic methodology in psychological research *Journal of Humanistic Psychology*, 9: 53-70.

Kiesler, R.J (1966) Some myths of psychotherapy research and the search for paradigm. In A.P. Goldstein & N. Stein (Eds.) *Prescriptive psychotherapy* New York: Pergamon, 102-126.

Kirschenbaum, H., & Henderson, V.L. (1990) *Carl Rogers Dialogues*. London: Constable.

Knowles, M (1984) *Andragogy in Action: applying the principles of adult education*, San Francisco: Jossy-Bass.

Kolb, D.A. (1984) *Experiential Learning: experience as the source of learning and development*. Englewood Cliffs, NJ: Prentice Hall.

Kornblith, S.J., Rehm, L.P., O'Hara, M.W., & Lamparski, D.M. (1983) The contribution of self-reinforcement training and behavioural assignments to the efficacy of self-control therapy for depression. *Cognitive Therapy and Research*, 7: 499-528.

Kuyken, W (2006), Evidence-based case formulation: is the emperor clothed? In N. Tarrier (Ed,) *Case Formulation in Cognitive Behaviour Therapy: The Treatment of Challenging and Complex Cases*. Hove: Routledge, 12-35.

Layden, M.A., Newman, C., Freeman, A., & Morse, S.B (1993) *Cognitive therapy of borderline personality disorder*. Boston: Allyn & Bacon.

Leahy, R.L. (2001). *Overcoming Resistance in Cognitive Therapy*. New York: Guilford.

Leahy, R.L. (2003). *Cognitive Therapy Techniques: a practitioner's guide*. New York: Guilford.

Leahy, R.L. (2005) *The Worry Cure: Seven steps to stop worry from stopping you*. London: Harmony.

Leahy, R.L., & Holland, S.J. (2000) *Therapeutic Plans and Interventions for Depression and Anxiety disorders*. New York: Guilford.

Leiper, R (2005) Psychodynamic formulation, in Johnstone, L., & Dallos, R (Eds.) *Formulation in and Psychology and Psychotherapy*, London: Routledge, 39-78.

Lincoln, Y.S., & Guba, E.G (1985) *Naturalistic Enquiry*, Newbury Park, CA: Sage.

Linehan, M.M (1993) *Cognitive-behavioral Treatment for Borderline Personality Disorder.*, New York: Guilford.

Linklater, S (2006) After Freud, *Prospect, 126: 36-41.*

Lomas, P (1987) *The Limits of Interpretation.* Harmondsworth: Penguin Books.

Lomas, P. (1994) *Cultivating Intuition*, Harmondsworth: Penguin Books.

Lomas, P. (1999). *Doing Good?* Oxford: Oxford University Press.

Luborsky, L., Singer, B., & Luborksy, E. (1975) Comparative studies of psychotherapies: Is it true that 'Everyone has won and all must have prizes?' *Archives of General Psychiatry,* 32: 995-1008.

Luborsky, L., Rosenthal, R., Diguer, L., Andrusyna, T.R., Berman, J.S., Levitt, J.T., Seligman, D.A., & Krause, E.D. (2002) The Dodo Bird verdict is alive and well – mostly. *Clinical Psychology: Science and Practice,* 9.1: 2-12.

Mackay, H.C., West, W., Moorey, J., Guthrie, E., & Margison, F. (2001) Counsellors' experiences of changing their practice: learning the psychodynamic-interpersonal model of therapy *Counselling and Psychotherapy Research,* 1.1: 29-35.

McGuire, J. (Ed, 1995) *What Works: reducing offending.* Chichester: Wiley.

McLeod, J. (2003) *Introduction to Counselling,* 3rd Edition London: Sage.

McNally, R.J. (1993) Self-representation in post-traumatic stress disorder: a cognitive perspective. In Z.V. Segal, & S.J. Blatt (Eds., 1993) *Self-representation and Emotional Disorder: cognitive and psychodynamic perspectives.* New York: Guilford.

Mahoney, M. (1974) *Cognition and Behaviour Modification* Cambridge: Ballinger.

Malan, D.H. (1976), *The Frontiers of Brief Psychotherapy: an example of the convergence of research and clinical practice.* New York: Plenum Press.

March, P. (1997) In two minds about cognitive therapy? *British Journal of Psychotherapy,* 13.4: 461-472.

Markowitz, J.C. (1995) "Why more dysthymic patients may not have improved" - Reply. *American Journal of Psychiatry.* 152.8: 1241

Markowitz, J. *C (2001)* Learning the new psychotherapies, in Weissman, M.M, *Treatment of Depression*, Washington: American Psychiatric Press, 281-296.

Marmar, C.R., & Gaston, L *(1988) Manual for the California Psychotherapy Scale (CALPAS).* Unpublished manuscript, Dept. of Psychiatry, University of California, San Francisco.

Mason, J. (2002) *Qualitative Researching,* 2nd Edition. London: Sage.

Mathews, A., & McLeod, C. (1985) Selective processing of threat cues in anxiety states. *Behaviour Research and Therapy,* 23:563-569.

May, T. (2001) *Social Research: issues, methods and process,* 3rd Edition. Buckingham: Open University Press.

Mearns, D. & Thorne, B. (1999). *Person-centred Counselling in Action.* 3rd Ed. London: Sage.

Meichenbaum, D. (1977) *Cognitive Behavioural Modification: an integrative approach,* New York: Plenum.

Mellor-Clark, J (2004) A review of the evolution of research evidence and activity in primary care counselling, *Psychodynamic Practice,* 10.3: 373-393.

Merriam, S.B (1993) *An Update on Adult Learning Theory,* San Francisco: Jossey-Bass.

Merriam, S.B (2001) *The New Update on Adult Learning Theory,* San Francisco: Jossey-Bass.

Messer, S.B., & Warren, C.S. (1998) *Models of Brief Psychodynamic Therapy: a comparative approach.* New York; Guilford.

Meyer, V. & Chesser, E.S. (1970), *Behaviour Therapy in Clinical Psychiatry.* London: Penguin.

Meyer, V. & Turkat, I.D. (1979) Behavioural analysis of clinical cases. *Journal of Behavioural Assessment,* 1: 259-269.

Miles, M.B., & Huberman, A.M. (1994) *Qualitative data analysis: an expanded sourcehood,* London: Sage.

Milne, D.L., Baker, C., Blackburn, I-M., James, I., & Reichelt, K. (1999) The effectiveness of cognitive therapy training. *Journal of Behaviour Therapy and Experimental Psychiatry,* 30.2: 81-92.

Milne, D.L., Claydon, T., Blackburn, I-M., Jarnes, I., & Sheikh, A (2001) Rationale for a new measure of competence in cognitive therapy, *Behavioural and Cognitive Psychotherapy,* 29: 21-33.

Milrod, B., Leon, A.C., Busch, F., Madden, M., Schwalberg, M., Clarkin, J., Aronson, A., Singer, M., Truchin, W., Klass, E.T., Graf, E., Teres, T.J., & Shear, K.M (2007) A randomised clinical trial of psychoanalytic therapy for panic disorder, *American Journal of Psychiatry,* 164: 265-272.

Milton, J. (2001) Psychoanalysis and cognitive behaviour therapy: rival paradigms or common ground? *International Journal of Psychoanalysis*, 82:3: 431-447.

Milton, J., Richardson, P., & Hale, R. (1999) Note on editorial in BMJ. http://www.psychoanalysis.org.uk/note3.htm (*British Psychoanalytical Society* website, accessed, 17/11/05).

Mooney, K., & Padesky, C (1998) Therapist beliefs, keynote lecture, European Association of Cognitive Behaviour Therapy Annual Conference, Cork, September, 1998. Text available: www.padesky.com

Morgernstern, J., Morgan, T.J., McCrady, B.S., Keller, D.S., & Carroll, K.M. (2001) Manual-guided Cognitive Behavioral Therapy Training: A Promising method for Disseminating Empirically Supported Substance Abuse Treatments to the Practice Community. *Psychology of Addictive Behaviors*, 15.2: 83-88.

Murdoch, J.W. & Connor-Greene, P.A. (2000) Enhancing impact and therapeutic alliance through electronic mail and homework assignments. *Journal of Psychotherapy Practice and Research*, 9.4: 232-237.

Myles, P.J., & Milne, D.L (2004) Outcome evaluation of a brief shared learning programme in cognitive behaviour therapy, *Behavioural and Cognitive Psychotherapies*, 32: 177-188.

National Institute for Clinical Excellence (NICE, 2005) Assessment Report: Computerised Cognitive Behavioural Therapy. www.nice.org.uk page.aspx?0=247815. (Accessed 24 November, 2005 at 1430)

Nehemas, A. (1998) *The Art of Living: Socratic Reflections from Plato to Foucault.* Berkeley: University of California Press.

Neighbour, R. (1992) The Inner Apprentice: an awareness-based approach to Vocational Training for General Practice. Newbury: Petroc Press.

Neimeyer, R.A; Feixas, G (1990) The role of homework and skill acquisition in the outcome of group cognitive therapy for depression. *Behavior Therapy*, 21.3: 281-292

Nelson-Jones, R. (2003) *Practical Counselling & Helping Skills*, 4th Ed. London: Sage.

Newnes, C., Holmes, G., & Dunn, C. (2001) *This is Madness Too.* Llangaron, UK: PCCS Books.

Norcross, J.C., & Arnkoff, S.L. (1992) Integrative and eclectic therapy: an overview, in W.Dryden (Ed.) *Integrative and Eclectic Therapy: a handbook*, Buckingham: Open University Press, 13-42.

O'Connell, B. (2001) *Solution Focused Stress Counselling.* London: Continuum

Oppenheim, A.N., (2000) *Questionnaire Design, Interviewing and Attitude Assessment,* London: Continuum.

Onions, C.T. (Ed., 1973) *The Shorter Oxford English Dictionary.* Prepared by William Little, H.W. Fowler, J. Coulson. Revised and edited by C.T.Onions. Oxford: Clarendon Press.

Orlinsky, D.E., Grawe, K., & Parks, B.K. (1994, 4th Ed.) Process and outcome in psychotherapy. In A.E. Bergin & S.L. Garfield (Eds., 1994) *Handbook of Psychotherapy and Behaviour Change.* New York: Wiley.

Ottaviani, R., & Beck, A.T (1987) Cognitive aspects of anxiety disorders, *Journal of Anxiety Disorders,* 1: 15-28.

Padesky, C.A. (1993) 'Socratic Questioning: Changing minds or guiding discovery?' Keynote address, given to the European Congress of Behavioural and Cognitive Psychotherapies, London, Sept., 1993. Text available: www.padesky.com

Padesky, C.A. (1994) *Cognitive Therapy for Anxiety*: Audiotape. Newport Beach, Cal: Centre for Cognitive Therapy.

Padesky, C.A. (1996) Developing Cognitive Therapist Competency: Training and Supervision Models. In P. Salkovskis, (Ed., 1996) *Frontiers of Cognitive Therapy.* New York: Guilford, 226-292.

Padesky, C.A. & Greenberger, D (1995) *The Clinician's Guide to Mind Over Mood* New York: Guilford.

Parry, G., & Richardson, P (1996, Eds.) *NHS Psychotherapy Services in England: Review of Strategic Policy.* London: HMSO.

Patton, M.Q. (2002) *Qualitative Research and Evaluation Methods,* 3rd Edition. Thousand oaks, CA: Sage.

Payne, R., & Blanchard, E.B (1995) A controlled comparison of cognitive therapy and self-help for irritable bowel syndrome. *Behavior Therapy,* 18: 70-83.

Persons, J (1989) *Cognitive therapy: A Case Formulation Approach.* New York: W.W.Norton & Co.

Persons, J. B. (1995). Why practicing psychologists are slow to adopt empirically-validated treatments. In S. C. Hayes, V. M. Follette, R. M. Dawes, & K. E. Grady (Eds.), *Scientific standards of psychological practice: Issues and recommendations.* Reno, NV: Context Press, 141-157.

Persons, J.B., Burns, D.D., & Perloff, J.M (1988) Prevalence of drop-out and outcome in cognitive therapy for depression in a private practice *Cognitive Therapy and Research.* 12: 557-575.

Persons, J. B., Gross, J. J., Etkin, M. S., & Madan, S. K (1996) Psychodynamic therapists' reservations about cognitive-behaviour therapy: Implications for training and practice. *Journal of Psychotherapy Practice and Research*, 5: 202-212.

Petty, R.E & Cacioppo, J.T.(1981) *Attitudes and Persuasion - classic and contemporary approaches* in R.E. Petty, T.M. Ostrom, & T. C. Brock (Eds) *Cognitive responses in persuasion,* Hillsdale, N.J.:L. Erlbaum Associates.

Petty, R.E, & Cacioppo, J.T (1986). The Elaboration Likelihood Model of Persuasion *Advances in Experimental Social Psychology*, 19, 123-205.

Petty, R.E., & Krosnik, J.A (1996) *Attitude Strength: antecedents and consequences.* Marwah, N.J: Lawrence Erlbaum.

Piaget, J. (1950) *The Psychology of Intelligence*. [translated from the French by Malcolm Piercy and D.E. Berlyne]. London: Routledge & Kegan Paul.

Pointon, C (2008) *The New Black, Therapy Today*, 3: 4-7.

Pollack, W.S (1999) Dynamic psychotherapy. In M. Hersen & Bellack, A S. (Eds.,1999). *Handbook of Comparative Interventions for Adult Disorders* (2nd Ed.) New York: John Wiley & Sons, 515-554.

Popper, K.R. (1959) *The Logic of Scientific Discovery.* London: Routledge.

Rachman, S (1997a) *Anxiety,* Hove: Psychology Press.

Rachman, S (1997b) 'The evolution of cognitive behaviour therapy,' In D.M. Clark, D.M. & Fairbairn, C. (Eds, 1997) *The Science and Practice of Cognitive Behaviour Therapy.* Oxford: Blackwell, 1-26.

Raimy, V.C. (1975), *Misconceptions about The Self.* San Francisco: Jossey-Bass.

Reichelt, K.F., James, I.A., & Blackburn, I-M (2003) The impact of training for rating competency in cognitive therapy, *Journal of Behavioural, Therapeutic & Experimental Psychiatry,* 34.2: 87-99.

Rescorla, R.A. (1986) Pavlovian conditioning: it's not what you think, *American Psychologist,* 43: 151-160.

Ritchie, J., & Lewis, J. (Eds., 2003) *Qualitative Research Practice: a guide for social science students and researchers.* London: Sage.

Robson, C (2002) *Real World Research: a resource for social scientists and practitioner researchers,* 2nd Ed., Oxford: Blackwell.

Rogers, C.R. (1942) *Counselling and Psychotherapy: newer concepts in practice.* Boston: Houghton-Mifflin.

Rogers, C.R. (1951) *Client Centred Therapy: its current practice, implications and theory.* Boston: Houghton-Mifflin.

Rogers, C.R. (1957) The necessary and sufficient conditions for therapeutic personality change *Journal of Consulting Psychology,* 21.2: 95-103.

Rogers, C.R. (1967) *On Being a Person: a therapist's view of psychotherapy.* London: Constable.

Rogers, C.R. (1980) *A Way of Being,* Boston: Houghton-Mifflin.

Rogers, C.R., & Russell, D. (2002) *Rogers: the Quiet Revolutionary: an oral history,* Roseville, California: Penmarion Books.

Rosenthal, H.G (Ed) (2001) *Favourite Counselling and Therapy Homework Assignments: Leading therapists share their most creative strategies.* Philadelphia, PA: Brunner-Routledge.

Roth, A. & Fonagy, P (1996) *What Works for Whom? A Critical Review of Psychotherapy Research,* New York: Guilford Press.

Roth, A.D., & Pilling, S. (2007) *The competencies required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety:* London: Department of Health.

Rowlands, N., & Goss, S (2002) *Evidence-based Counselling and Psychological Therapies: research and applications.* London: Routledge.

Roy-Byrne, P.P., Craske, M.G., Stein, M.B., Sullivan, G.C., Bystritsky, A., Katon, W., Golinellis, D., & Sherbourne, C.D (2005) A randomised effectiveness trial of cognitive behaviour therapy and medication for primary care panic disorder *Archives of General Psychiatry,* 62.3: 290-295.

Rushton, R., & Davis, H. (1992) An evaluation of effective counselling skills training for health care professionals. *British Journal of Guidance & Counselling,* 20: 205-220.

Russell, J., & Dexter, G (1993) Ménage a trois: Accreditation, NVQ and BAC? *Counselling,* 4.4: 51-57. Rugby: BAC.

Safran, J.D, & Segal, Z.V. (1990) *Interpersonal Processes in Cognitive Therapy.* New York: Basic Books.

Safran, J.D & Muran, J.C (2000) *Negotiating the Therapeutic Alliance: a relational treatment guide.* New York: Guilford.

Salkovskis, P.M. (Ed., 1996) *The Frontiers of Cognitive Therapy.* New York: Guilford.

Salkovskis, P., Forrester, E., Richards, H.C., & Morrison, N (1998) The devil is in the detail: conceptualising and treating obsessional problems, in Tarrier, N (Ed.) *Treating Complex Cases: the cognitive behavioural therapy approach*, Chichester: Wiley, 46-80.

Salkovskis, P.M., Clark, D.M., & Gelder, M.G. (1996) Cognition-behaviour links in the persistence of panic. *Behaviour Research and Therapy*, 34: 453-458.

Sanderson, W.C. (2003) Why empirically supported treatments are important. *Behavior Modification*, 27.3: 290-299.

Sanderson, W.C., Rapee, R.M., & Barlow, D.H. (1989) The influence of an illusion of control on panic attacks induced via inhalation of 5.5% carbon dioxide enriched air. *Archives of General Psychiatry*, 46: 157-162.

Schon, D.A (1983) *The Reflective Practitioner: How professionals think in action*, New York: Basic Books.

Schultheis, G.M., O'Hanlon, B., O'Hanlon, S. (1999). *Brief Couples Therapy Homework Planner*. New York: John Wiley and Sons.

Seeman, J. (1997) When does a beginning begin? *American Psychologist*, 52.10: 1140-1141.

Segal, Z.V., Williams, J.M.G., & Teasdale, J.D. (2002) *Mindfulness-based Cognitive Therapy for Depression: a new approach to preventing relapse*. New York: Guilford.

Shapiro, F. (1995) *EMDR: The breakthrough therapy for anxiety, stress & trauma*. New York: Basic Books.

Shapiro, D.A., Cavanagh, K., & Lomas, H (2003), Geographic inequity in the availability of cognitive behaviour therapists in England & Wales, *Behavioural and Cognitive Psychotherapy*, 31.2: 185-192.

Shaw, B.F. (1988) The value of teaching psychotherapy techniques: a response. *Journal of Cognitive Psychotherapy: An International Quarterly*, 2.2: 83-87.

Shaw, B.F. & Dobson, D.S. (1988) Competency judgements in the training and evaluation of psychotherapists. *Journal of Consulting and Clinical Psychology*, 56: 666-672.

Shaw, B.F., Elkin, I., Yamaguchi, J., Olmsted, M., Vallis, T.M., Dobson, K.S., Lowery, A., Sotsky, S.M., Watkins, J.T., & Imber, S.D. (1999). Therapist competency ratings in relation to clinical outcome in cognitive therapy of depression. *Journal of Clinical and Consulting Psychology*, 67: 837-846.

Shear, M.K., Pilkonis, P.A., Cloitre, M., & Leon, A.C. (1994) Cognitive behavioural treatment compared with non-prescriptive treatment of panic disorder. *Archive of General Psychiatry*, 51: 395-401.

Sheldon, B. (1995), *Cognitive-behavioural Therapy: research, practice and philosophy*. London; New York: Routledge.

Shultz, T. R., & Lepper, M. R. (1996). Cognitive dissonance reduction as constraint satisfaction. *Psychological Review*, 103: 219-240.

Smith, J.A., Harre, R., & Van Langehore (Eds. 1995) *Rethinking Methods in Psychology.* London: Sage.

Smith, M.L., Glass, G.V., & Miller, T.I. (1980) *The Benefits of Psychotherapy.* Baltimore, MD: John Hopkins University Press.

Sloane. R.F., Staples, A., Yorkston, C.N., & Whipple, K (1975) *Psychotherapy versus Behavior Therapy,* Cambridge, MA: Harvard.

Soanes, C., & Stevenson, A (Eds. 2004) *Concise Oxford English Dictionary.* Oxford: Oxford University Press.

Speedy, J (1998) Negotiated learning and assessment, in H. Johns (Ed.) *Blancing acts: studies in counselling training,* London: Routledge, 82-95.

Spong, S., & Hollanders, H. (2003) Cognitive therapy and power. *Counselling and Psychotherapy Research Journal,* 3.3: 216-222.

Steketee, G & Piggott, T. (2002) *Obsessive-compulsive Disorder.* Kansas City: Compact Clinicals.

Stewart, N.R. (1978) *Systematic Counseling*. Englewood Cliffs, NJ: Prentice Hall.

Streiner, D.L., & Norman, G.R. (2003), *Health Measurement Scales: A practical guide to their development and use.* Oxford: Oxford University Press.

Stricker, G (2006) Using homework in psychodynamic psychotherapy, *Journal of Psychotherapy Integration,* 16.2: 219-237.

Strong, S.R., & Matross, R.P. (1973) Change processes in counselling. *Journal of Consulting Psychology,* 20: 25-37.

Strupp, H.H., Butler, S.F., & Rosser, C.L (1988) Training in psychodynamic therapy *Journal of Consulting and Clinical Psychology,* 56.5: 689-695.

Sudak, D.M., Beck, J.S., & Wright, J. (2003) Cognitive behavior therapy: a blueprint for attaining and assessing psychiatric resident competency. *Academic Psychiatry,* 27: 143-159.

Taylor, C.B. & Luce, K.H. (2003) Computer and internet-based psychotherapy interventions. *Current Directions in Psychological Science,* 12.1: 18-22.

Teasdale, J.D (1993) Emotion and two kinds of meaning: cognitive therapy and applied cognitive science, *Behaviour Therapy and Research,* 31: 339-345.

Teasdale, J.D. (1996) Clinically relevant theory: integrating clinical insight into cognitive science. In Salkovskis, P (Ed., 1996) *Frontiers of Cognitive Therapy*. New York: Guilford, 26-47.

Teasdale, J.D., & Barnard, P.J. (1993) *Affect, Cognition and Change: remodelling depressive thought*. Hove, UK: Erlbaum.

Thase, M. (1994) After the Fall: Perspectives on the cognitive behaviour therapy of depression in the 'post-Collaboration' era. *Behavior Therapist*, 2: 48-51.

Tight, M (2002) *Key Concepts in Adult Education and Training*, 2nd Edition, London: Routledge Falmer.

Tolan, J. (2003) *Skills in Person-centred Counselling and Psychotherapy*, London: Sage.

Trepka, C., Rees, A., Shapiro, D.A., Hardy, G.E., & Barkham, M. (2004) Therapist competence and outcome of cognitive therapy of depression. *Cognitive Therapy and Research*, 28.2: 154-159.

Truax, C., & Carkhuff, R.R (1967) *Toward Effective Counselling and Psychotherapy: Training and practice*. Chicago: Aldine.

Turkat, I.D. (1979) The behavior analysis matrix. *Scandinavian Journal of Behaviour Therapy*, 8: 187-189.

Turkat, I.D. (1985) *Behavioural Case Formulation*. New York: Plenum.

Turkat, I.D. (1990) *The Personality Disorders. A psychological approach to clinical management*. New York: Pergamon.

University of Wales Newport (UWN, 2004) *Programme Handbook for the Modular Masters in Counselling*, Newport: UWCN.

Vallis, T.M., Shaw, B.F., Dobson, K.S. (1986) The cognitive therapy scale: psychometric properties. *Journal of Consulting and Clinical Psychology*, 54.3: 381-385.

Van den Hout, M., Arntz, A., & Hoekstra, R. (1994) Exposure reduced agoraphobia but not panic; cognitive therapy reduced panic but not agoraphobia. *Behaviour Research and Therapy*, 32: 447-451.

Van Deurzen-Smith, E. (2002) *Existential Counselling and Psychotherapy*: London: Sage.

Weishaar, M (1993). *Aaron.T.Beck*, London: Sage.

Weissman, M.M., Markowitz, J.C., & Klerman, G.L. (2000), *Comprehensive Guide to Interpersonal psychotherapy*. New York: Basic Books.

Wells, A. (1997) *Cognitive Therapy of Anxiety Disorders*. Chichester: Wiley.

Wells, A. (2000) *Emotional Disorders and Metacognition: Innovative Cognitive Therapy*. Chichester: Wiley.

Wells, A., & Matthews, G. (1994) *Attention and Emotion: a clinical perspective*. Hove, UK: Erlbaum.

White, D (2008) Good going at Doncaster IAPT, *Therapy Today*, 3: 10-14.

Whisman, M.A (1993) Mediators and moderators of change in cognitive therapy of depression. *Psychological Bulletin*, 114.2: 248-265.

Williams, C. (2002) Using Structured Cognitive Behaviour Therapy Self-help Materials in a Clinical Service *Psychiatry*, 1.3: 28-31.

Williams, R.M., Moorey, S., & Cobb, J (1991) Training in cognitive behaviour therapy: a pilot evaluation using the cognitive therapy scale, *Journal of Behavioural Psychotherapy*, 19.4: 373-376.

Williams, S. J., Calnan, M. and Gabe, J. (Eds) (2000) *Health, Medicine and Society. Key Theories, Future Agendas*. Routledge Press.

Wills, F (2006) Cognitive therapy: a down to earth and accessible therapy, in C.Sills (Ed.) *Contracts in Counselling and Psychotherapy*, London: Sage, 41-51.

Wilkins, P. (2002) *Person Centred Counselling in Focus*. London: Sage.

Woolfe, R. & Dryden, W. (Eds) (1996) *The Handbook of Counselling Psychology*. London: Sage.

Wolpe, J. (1958) *Psychotherapy by Reciprocal Inhibition*. Stanford: Stanford University Press.

Xenakis, I. (1969) *Epictetus: Philosopher-therapist*. Xenakis.

Young, J.S & Beck, A.T (1980) *The Cognitive Therapy Scale*: rating manual Philadelphia: Center for Cognitive Therapy.

Young, J.S & Beck, A.T (1988) *The Revised Cognitive Therapy Scale*. Philadelphia: Center for Cognitive Therapy.

Young, J.S., Klosko, J., & Weishaar, M (2003) *Schema therapy: A practitioner's guide*. New York: Guilford.

APPENDICES

APPENDIX 1: Letter to trainees and CBTTQ:

School of Health and Social Care,
University of Wales Newport,
PO Box 180,
NEWPORT,
South Wales, NP20 5XR.

16 September 2000.

Dear Student,

CNT Training research study:

Further to our discussion at the pre-course meeting earlier this week, I am pleased to send you the first of the 3 questionnaires that I told you about. It has come to you via Mike Simmons who is co-ordinating data collection for me. We are using this system to ensure that your responses are confidential. You will see that there is a number written on your questionnaire. All data will be kept under this number, not by name. This study number will remain the same for you throughout the study. In the unlikely event of you being sent a future questionnaire with a different number, this means that there has been an error. In this event, please let Mike know and he will endeavour to sort out what has gone wrong.

As I told you at the pre-course meeting, it is important for you to know you are fully entitled not to take part in the study and also that you may withdraw from it at any time, with no adverse consequences for yourself. Your responses will stay fully anonymous until after you have finished your training and education at UWN. After that I may need to identify your individual responses to match them up with other data regarding your training here. Any reporting of results will, however, be by your anonymous study number. If you have any concerns about this situation, please contact Mike Simmons, on 01633-432520, for further discussion and/or clarification.

The questionnaire has been designed to be comprehensive without being too burdensome. I am aware of the demand for questionnaire completion these days and want to thank you in advance for your forbearance. Please feel free to add any views you have about CBT training. I have left some spaces quite small to avoid making the questionnaire too long and unwieldy, so you might want to add more on an additional sheet of paper as an addendum.

May I also take this opportunity to remind you that all respondents returning questionnaire will be put into a prize draw. The draw will be made by Mike and the prize will be a £30 book token.

Thanks in advance once again for agreeing to help. Frank Wills

COGNITIVE BEHAVIOUR THERAPY TRAINING QUESTIONNAIRE (CBTTQ): PRE-TRAINING

A) Background Information

Phase FU Date

Study number Gender n/a Age n/a

Present job/occupation

Time in post

Previous job/occupation

Education/Training: (no response needed) GCSE/O-levels A-levels Degree Postgraduate
(Please circle all relevant responses)

Professional Qualifications
n/a_____

_____

Other _____

B) Employers' attitudes towards training in CBT

i) Does your employer support your CBT training by:
- *** Giving time off to attend**
- *** Paying part or all course fees**
- *** Paying a book allowance**
- *** Arranging appropriate supervision**
- *** Other** _____

(Please tick all relevant responses)

ii) Does your employer regard CBT training as:

very high priority quite high priority quite low priority low priority
(Please circle)

iii) How strongly would you rate your employer's support

very strong quite strong quite weak very weak (please circle)

iv) Will having a qualification in CBT prove to be an advantage in relation to things like promotion in your workplace?

YES NO NOT SURE (please circle)

Why/Why not? _____

V) What do you expect to be doing 2 years after the completion of the course?

n/a

C) Attitude to principles of CBT

i) Thinking of your practice now, rank orders the following models that influenced your practice. (NB The rank order 1 = the model that exercises most influence, 2 = the next most influential etc.)

Behaviour therapy ____ Person-centred therapy ____ Psychodynamic therapy ____
CBT ____ Eclectic/Integrated ____ Other (Name _____) ____

ii) How strongly does your practice show adherence to the model given rank 1 above?

very strong quite strong quite weak very weak

iii) Rate the following principles of CBT in terms of how much you agree with them as key principles for a model of psychotherapy to follow. It may be difficult to assess each principle in an abstract context, but try to consider them in relation to work with your most typical clients. Tick the appropriate rating and add any comments you would like to below each principle.

a) Therapy should be based on an ever-evolving conceptualisation of the client and his/her problems in cognitive terms.

Strongly disagree Disagree Agree strongly agree

b) A sound therapeutic relationship is necessary but not sufficient for effective therapy

Strongly disagree disagree agree strongly agree

c) Therapy should emphasise collaboration and active participation

Strongly disagree disagree agree strongly agree

d) Therapy should be goal-orientated and problem-focused.

Strongly disagree disagree agree strongly agree

e) Therapy initially emphasise the present rather than the past

Strongly disagree disagree agree strongly agree

f) Therapy should be educative, aiming to teach clients to be their own therapists

Strongly disagree **disagree** **agree** **strongly agree**

g) Therapy should aim to be time-limited.

Strongly disagree **disagree** **agree** **strongly agree**

h) Therapy sessions should be structured

Strongly disagree **disagree** **agree** **strongly agree**

i) Therapy sessions should teach clients to identify, evaluate and respond to their negative thoughts and beliefs

Strongly disagree **disagree** **Agree** **Strongly agree**

j) Therapy should emphasise the importance of homework/learning tasks between sessions

Strongly disagree **Disagree** **Agree** **Strongly agree**

D) Learning CBT:

i) What do you expect will be the most difficult aspects of learning CBT?

ii) How will your practice change as a result of doing CBT training?

E) FINALLY

i) I would like to be sent a summary of the results of the research YES NO

ii) Supplementary points about any of the questions in the questionnaire (Please precede your points with the number of the question to which they refer.)

iii) Any points you might like to make about the subject being researched, the way it is being researched or about the questionnaire itself?

Thanks for filling this out. Please now use the stamped addressed envelope to send it back to the author's agent by _____.

COGNITIVE BEHAVIOUR THERAPY TRAINING QUESTIONNAIRE (CBTTQ)
END & FOLLOW-UP VERSION

A) Background Information

Phase FU Date

Study number Gender n/a Age n/a

Present job/occupation

Time in post

Previous job/occupation

Education/Training: (no response needed) GCSE/O-levels A-levels Degree Postgraduate
(Please circle all relevant responses)

Professional Qualifications
n/a_____

_____

Other _____

B) Employers' attitudes towards training in CBT

i) Did your employer support your CBT training by:
- *** Giving time off to attend**
- *** Paying part or all course fees**
- *** Paying a book allowance**
- *** Arranging appropriate supervision**
- *** Other** _____

(Please tick all relevant responses)

ii) Did your employer regard CBT training as:

very high priority quite high priority quite low priority low priority
(Please circle)

iii) How strongly would you rate your employer's support

very strong quite strong quite weak very weak (please circle)

iv) Will having a qualification in CBT prove to be an advantage in relation to things like promotion in your workplace?

YES NO NOT SURE (please circle)

Why/Why not? _____

V) What do you expect to be doing 2 years after the completion of the course?

n/a

C) Attitude to principles of CBT

i) Thinking of your practice now, rank orders the following models that influenced your practice. (NB The rank order 1 = the model that exercises most influence, 2 = the next most influential etc.)

Behaviour therapy ____ Person-centred therapy ____ Psychodynamic therapy ____
CBT ____ Eclectic/Integrated ____ Other (Name _____) ____

ii) How strongly does your practice show adherence to the model given rank 1 above?

very strong quite strong quite weak very weak

iii) Rate the following principles of CBT in terms of how much you agree with them as key principles for a model of psychotherapy to follow. It may be difficult to assess each principle in an abstract context, but try to consider them in relation to work with your most typical clients. Tick the appropriate rating and add any comments you would like to below each principle.

b) Therapy should be based on an ever-evolving conceptualisation of the client and his/her problems in cognitive terms.

Strongly disagree Disagree Agree strongly agree

b) A sound therapeutic relationship is necessary but not sufficient for effective therapy

Strongly disagree disagree agree strongly agree

c) Therapy should emphasise collaboration and active participation

Strongly disagree disagree agree strongly agree

d) Therapy should be goal-orientated and problem-focused.

Strongly disagree disagree agree strongly agree

e) Therapy initially emphasise the present rather than the past

Strongly disagree disagree agree strongly agree

f) Therapy should be educative, aiming to teach clients to be their own therapists

Strongly disagree **disagree** **agree** **strongly agree**

g) Therapy should aim to be time-limited.

Strongly disagree **disagree** **agree** **strongly agree**

h) Therapy sessions should be structured

Strongly disagree **disagree** **agree** **strongly agree**

i) Therapy sessions should teach clients to identify, evaluate and respond to their negative thoughts and beliefs

Strongly disagree **disagree** **Agree** **Strongly agree**

j) Therapy should emphasise the importance of homework/learning tasks between sessions

Strongly disagree **Disagree** **Agree** **Strongly agree**

D) Learning CBT:

i) What did you expect to be the most difficult aspects of learning CBT?

ii) How did your practice change as a result of doing CBT training?

E) FINALLY

i) I would like to be sent a summary of the results of the research YES NO

ii) Supplementary points about any of the questions in the questionnaire (Please precede your points with the number of the question to which they refer.)

iii) Any points you might like to make about the subject being researched, the way it is being researched or about the questionnaire itself?

Thanks for filling this out. Please now use the stamped addressed envelope to send it back to the author's agent by _____

APPENDIX 2:
TRAINING IN COGNITIVE BEHAVIOUR THERAPY
Semi-structured Interview Schedule

INTERVIEW WITH CBT TRAINEES

Study number _ _ _ _

Course Cohort __ / __

Date of interview / /

Place of interview _____

INTRODUCING THE INTERVIEW

Thanks for agreeing to be interviewed about your experiences learning Cognitive Behaviour Therapy. The interview is designed to last between 50 and 60 minutes. It will be divided into three sections – your experiences before, during and after the training course. I will ask you some questions but please feel free to expand or add points, as they seem relevant to you.

A. BEFORE THE CB TRAINING COURSE

A1.
How did your interest in Cognitive Behaviour Therapy begin?

A2.
When did your interest in Cognitive Behaviour Therapy begin?

A3. ***What was your preferred counselling model at that time?***	

A4. **How strongly did you believe that your preferred model was an effective method?**	

A5. **How did you see CBT fitting in with your current practice of that time?**	

A6. **What factors finally led you to decide to do CBT training?**	

A7. **What were your main hopes and fears about learning Cognitive Behaviour Therapy at the start of training?**	

A8. **Are you employed or self-employed?** **Part-time or full time?** **<u>If employed</u>, what was your employer's attitude towards you doing a CBT course?**	

B. DURING CB TRAINING:

B9.
How were you feeling about the training course at around the halfway point? (Prompt – 'As you handed in your first assessed tape')

B10.

What aspects of CBT training did you gain most from?

(Prompt - If more than one, rank order)

B11. **What aspects of CBT training were most difficult?** **(Prompt - If more than one, rank order)**	

B12. **How did what you were learning in CBT training work out in practice when you tried it with clients?** **(Prompt – did it seem to work quite well with most of the clients you tried it with?)**	

B13.

How would you describe your development as you moved into the final stages of CBT training?

(Prompt – Around the time of the second assessment tape)

If answered SELF-EMPLOYED to Question A8, move to Question C 15.

B14.
How has your completion of CBT training been recognised and/or rewarded by the your employer/s?

C. AFTER CB TRAINING: **C15.** **Would you now describe yourself as a Cognitive Behaviour Therapist?** **If NO or OTHER, what term do you use to describe yourself as a practitioner?**	/
C16. **To what extent to you now use CBT in your regular daily practice with clients?**	

C17. **Looking back at how you saw CBT at the start of the training course, would you say that you see CBT differently now? (If YES, In what ways?)** **(Prompt #1– refer back to answer for Question A7)** **(Prompt #2 – Big shift, small shift, mixed bag?)**	

C18. **What role do you expect CBT will play in your practice in the future?**	

C19. **How likely is it that you will become *involved in the British* Association for Behavioural & Cognitive Psychotherapies (BABCP) – for example, by seeking accreditation or by attending conferences etc?** **(Prompt – Or Other relevant professional associations?)**	
C20. **Finally, how would you assess the impact that doing CBT training has had and will have on the development of your career?**	

Finally, thanks very much for answering these questions. Are there any final points that you would like to add?

May I also ask you how you felt about the interview process?

Do you think that you might answered the questions differently with another interviewer?

I would like to send you a draft of my write-up of this interview to ensure that I have recorded what you have said accurately. Is that okay with you?

I am also going to write up a brief report of my final findings. Would you like me to send you a copy of this brief report?